



**Individual PPO Share \$7,500
06BY**

Dear Individual Member,

We would like to welcome you to Anthem Blue Cross and extend our thanks for choosing our health plan.

This booklet provides a complete statement of all the benefits available to you. Please read it carefully to be sure you fully understand your benefits, coverage, limitations and exclusions. For your convenience, at the front of this Combined Evidence of Coverage and Disclosure Form is a brief summary of the benefits provided by this booklet. This is only a summary; the agreement contains the exact terms and conditions of 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, claims status or your benefits under this Combined Evidence of Coverage and Disclosure Form, please feel free to contact our Customer Service Department at 1-800-333-0912 or P.O. Box 9051, Oxnard, California 93031-9051.

Thank you for choosing Anthem Blue Cross.

ANTHEM BLUE CROSS

A handwritten signature in black ink, appearing to read "Pam Kehaly".

Pam Kehaly
President
Anthem Blue Cross
Insurance Company

A handwritten signature in black ink, appearing to read "Kathy Kiefer".

Kathy Kiefer
Secretary
Anthem Blue Cross
Insurance Company

effective 9-23-2010

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HEALTH PLAN BENEFITS AND COVERAGE MATRIX

Contract Code: 06BY

INDIVIDUAL PPO SHARE \$7,500

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This is an overview of coverage. The Evidence of Coverage (EOC) contains the exact terms and conditions of coverage. You have a right to view the EOC prior to enrollment. To obtain a copy of the EOC, please call 1-800-333-0912.

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Annual Deductible	\$7,500		
Professional Services	0% of Negotiated Fee Rate (NFR).	50% of the Negotiated Fee Rate (NFR) plus all charges in excess of the NFR.	Office Visits not subject to Deductible.
Outpatient Services	<p>Preferred Participating Providers: 0% of the NFR.</p> <p>Participating Providers: 0% of the NFR plus \$500 admission charge for surgery or Infusion Therapy.</p>	All charges except \$380 per day.	<p>The \$500 admission charge will not be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit.</p> <p>The \$500 admission charge will not be required for Ambulatory Surgical Centers or Medical Emergency services.</p>
Hospitalization Services	<p>Preferred Participating Hospitals: 0% of the NFR.</p> <p>Participating Hospitals: 0% of the NFR plus \$500 admission charge.</p>	All charges except \$650 per day.	<p>The \$500 admission charge will not be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit.</p> <p>Bariatric surgical procedures and related services are covered only when performed at an Anthem CME. Preservice Review is required.</p> <p>Please refer to the EOC for further details.</p>

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Emergency Health Coverage	0% of the NFR.	<p>Within California:</p> <p>Physician: 0% of the Customary and Reasonable (C&R) charges or billed charges, whichever is less.</p> <p>Hospital: 0% of C&R charges or billed charges, whichever is less, plus all charges in excess of Customary and Reasonable.</p> <p>Ambulatory Surgical Center (ASC): 0% of C&R charges.</p> <p>Ambulance services: 0% of C&R charges.</p>	<p>Emergency Room services in the state of CA. for both Participating and Non-Participating Providers are subject to an additional \$100 Copayment per visit which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.</p> <p>Please refer to your EOC for further information about emergency care outside of California.</p> <p>The \$100 Emergency Room Copayment and Coinsurance paid on allowable charges will be applied towards the Member's Yearly Maximum Copayment/Coinsurance Limit.</p>
Ambulance Services Other Than in a Medical Emergency or Without an Authorized Referral	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Prescription Drug Coverage	<p>Retail Pharmacies</p> <p>Tier 1: \$15 Copayment or 40% of Prescription Drug Maximum Allowed Amount, whichever is greater. No Prescription Drug Deductible required for Tier 1 Drugs.</p> <p>Tier 2: 100% of Prescription Drug Maximum Allowed Amount until \$ \$750 Tier 2 Prescription Drug Deductible is satisfied then \$15 Copayment or 40% of Prescription Drug Maximum Allowed Amount, whichever is greater if no Tier 1 Drug is available.</p> <p>Tier 2 Prescription Drugs requested by Subscriber: After \$750 Tier 2 Prescription Drug Deductible \$15 Copayment or 40% of Prescription Drug Maximum Allowed Amount, whichever is greater plus the difference between Tier 2 Drug & Tier 1 Drug if Tier 1 Drug is available.</p> <p>Self-administered injectable Drugs (except Insulin): 30% of the Prescription Drug Maximum Allowed Amount.</p>	<p>Retail Pharmacies: The reimbursement will be 50% of the Prescription Drug Maximum Allowed Amount less the Copayment/Coinsurance as stated for Participating Pharmacies.</p>	<p>Copayment applies for each 30-day supply; 60-day supply available through mail order for an additional Copayment.</p> <p>No Prescription Drug Deductible required for Tier 1 Drugs.</p> <p>Prescription Drug Deductible: Two (2) Member family maximum.</p> <p>Prescription Drug Deductible applies to Tier 2 Prescriptions purchased through Mail Order and at Participating and Non-Participating Pharmacies combined.</p> <p>Refer to EOC for Prescription Drug Exclusions and Limitations.</p>

Mail Order:

Tier 1:

\$15 Copayment or 40% of Prescription Drug Maximum Allowed Amount, whichever is greater for each Prescription and/or refill for each 30 day supply or \$30 Copayment for up to a maximum 60 day supply. No Prescription Drug Deductible required for Tier 1 Drugs.

Tier 2:

After \$750 Prescription Drug Deductible \$15 Copayment or 40% of Prescription Drug Maximum Allowed Amount, whichever is greater for each Prescription and/or refill for each 30 day supply or \$30 Copayment for up to a maximum 60 day supply.

Mail Order

Not Applicable

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Durable Medical Equipment (Medical Supplies & Equipment)	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	Footwear limited to a maximum of \$400 per Year for Participating and Non-Participating Providers combined. Refer to EOC for all other Exclusions and Limitations.
Mental Health Services	<p>Inpatient Services: 0% of NFR.</p> <p>Professional Services: 0% of NFR</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition. Amounts you pay for these services will apply toward your Deductible and Yearly Maximum Copayment/Coinsurance Limit.</p>	<p>Inpatient Services: 50% of the NFR plus all charges in excess of the NFR</p> <p>Professional Services: 50% of the NFR plus all charges in excess of the NFR</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided as any other medical condition.</p>	<p>Inpatient Services: 30 days per Year maximum, combined with Chemical Dependency Services.</p> <p>Professional Services: One visit per day, 20 visits per Year combined with Chemical Dependency Services.</p> <p>Mental Health Services limitations do not apply to Treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. 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.</p>
Chemical Dependency Services	<p>Inpatient Services: 0% of NFR</p> <p>Professional Services: 0% of NFR.</p>	<p>Inpatient Services: 50% of the NFR plus all charges in excess of the NFR.</p> <p>Professional Services: 50% of the NFR plus all charges in excess of the NFR.</p>	<p>Inpatient Services: 30 days per Year maximum, combined with Inpatient Mental Health Services.</p> <p>Professional services: One visit per day, 20 visits per Year maximum, combined with Mental Health Services.</p>
Home Health Services	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	60 visits per Year maximum for Participating/Non-Participating Providers combined, up to 4 hours each visit.
Pregnancy and Maternity Services	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Physical Therapy, Occupational Therapy, Chiropractic Care	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	24 visits per Year maximum for Participating/Non-Participating Providers combined, additional visits as authorized by Anthem if Medically Necessary.
Skilled Nursing Facility	0% of the NFR.	50% of the NFR plus all charges in excess of the NFR.	100 days per Year maximum for Participating/Non-Participating Providers combined.
Infusion Therapy	0% of the NFR.	<p>Professional and Administering expenses: All charges in excess of \$50 per day for all expenses except Drugs.</p> <p>Drugs: All charges in excess of the Average Wholesale Price (AWP) plus all charges in excess of the per day maximum.</p>	Combined covered maximum will not exceed \$500 per day for Non-Participating Providers only.
Acupuncture and Acupressure	All of the NFR except \$30 per visit.	All charges except \$30 per visit.	24 visits per Year maximum for Participating/Non-Participating combined. Not subject to Deductible.
Outpatient Speech Therapy	0% of the NFR.	30% of C&R charges plus all charges in excess of C&R.	50 visits per Year maximum; additional visits are covered as authorized by Anthem if Medically Necessary. Refer to the EOC for additional information.

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out Of Network	
Yearly Maximum Copayment/Coinsurance Limit	\$7,500 per Member per Year, 2 Member maximum	Not Applicable	<p>Amounts you pay for: Acupuncture and Acupressure, Non-Participating Physical Therapy, Occupational Therapy and Chiropractic Care services, and services under the benefit entitled Mental or Nervous Disorders and Substance Abuse (except Severe Mental Illness and Serious Emotional Disturbances of a Child) do not accumulate to your Yearly Maximum Copayment/Coinsurance Limit. In addition, Prior Authorization Copayments, Prescription Drug Copayments, the additional Maternity Copayment and Hospital admission charges do not apply to your Yearly Maximum Copayment/Coinsurance Limit.</p> <p>Refer to your EOC for additional information about your Yearly Maximum Copayment/Coinsurance Limit.</p>

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INTRODUCTION

Anthem Blue Cross (“Anthem”) enters into this Agreement (“Agreement”) with you based upon the answers submitted by you and your Family Members on the signed Individual Enrollment Application. In consideration for the payment of the Subscription Charges stated in this Agreement, we will provide the services and benefits listed in this Agreement to you and your eligible Family Members.

For your convenience, at the front of this Agreement and Combined Evidence of Coverage and Disclosure Form, is a brief summary of the benefits provided by this booklet. The disclosure form is a summary only; the Agreement contains the exact terms and conditions of coverage. Please read the Agreement 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 AGREEMENT PRIOR TO ENROLLMENT.

You also have the right to receive a copy of the Member Rights and Responsibilities Statement and/or the Notice of Privacy Practices. You may obtain either document by calling our customer service department at 1-800-333-0912 or by accessing our web site at www.anthem.com/ca.

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating Physician may, after notice from us, be subject to a reduced Negotiated Fee Rate in the event the participating Physician fails to make routine referrals to Participating Providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. For additional information, you may contact us at 1-800-333-0912 or you may contact your participating Physician.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract 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 schedule an appointment. Call your prospective doctor, medical group, or clinic, or call customer service toll free at 1-800-333-0912 to ensure that you can obtain the health care services that you need.

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 1-800-333-0912.

In this Agreement, “we,” “us” and “our” mean Anthem. You are the eligible Subscriber whose application has been accepted by us. “You” and “your” shall also mean any eligible Family Members who were listed on your application and were accepted by us for coverage under this Agreement. When we use the word “Member” in this Agreement we mean you and any eligible Family Member covered under this Agreement.

The benefits of this Agreement are provided only for those services that Anthem determines are Medically Necessary and a Covered Service. If you have any questions as to whether a service is covered, consult this Agreement or call us at 1-800-333-0912. Our customer service representatives can assist you in determining the benefits of your Plan and, if necessary, help you obtain Preservice Review for the types of benefits that require Preservice Review. Our customer service representatives can also assist you with the selection of a Participating Provider in your area from our Participating Provider Directory and can give you information on some of our “Programs To Keep You Well.” A Participating Provider directory, or information on Participating Providers, may be obtained by calling our customer service department toll free at 1-800-333-0912 or by accessing our website at www.anthem.com/ca. Click on Provider Finder and follow the directions to find a Participating Provider in your area. The Participating Provider directory is updated quarterly and lists providers that have a Prudent Buyer Plan Participating Provider Agreement in effect with

us. Working together as partners in your health care can make your medical experiences less stressful and more cost effective to you.

YOU HAVE TEN (10) DAYS FROM THE DATE OF DELIVERY TO EXAMINE THIS AGREEMENT. IF YOU ARE NOT SATISFIED, FOR ANY REASON, WITH THE TERMS OF THIS AGREEMENT, YOU MAY RETURN THE AGREEMENT TO US WITHIN THOSE 10 DAYS. YOU WILL THEN BE ENTITLED TO RECEIVE A FULL REFUND OF ANY SUBSCRIPTION CHARGES PAID. THIS AGREEMENT WILL THEN NO LONGER BE IN EFFECT.

IF, DURING THE FIRST TWO YEARS OF MEMBERSHIP UNDER THIS AGREEMENT, WE DISCOVER ANY ACT, PRACTICE OR OMISSION THAT CONSTITUTES FRAUD OR AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS THAT YOU OR YOUR ELIGIBLE FAMILY MEMBERS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE WILL CANCEL THIS AGREEMENT BACK TO ITS EFFECTIVE DATE (see the part entitled DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT).

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY, ATTENDING PHYSICIAN AND OTHER PROVIDERS OF CARE: Nothing contained in this Agreement restricts or interferes with your right to select the Contracting Hospital, Skilled Nursing Facility, attending Physician, or other providers of your choice.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Throughout this Agreement, 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 Agreement where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

IMPORTANT!

This is not an annual Agreement. 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 AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT**, and is not affected by any provisions defining your Deductible or other cost sharing obligations. Your Agreement expires at the end of each billing cycle but will automatically renew upon timely payment of your next subscription charge, subject to our right to terminate, rescind, cancel or non-renew as described in the part entitled **DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT**, Paragraph D. Also, subscription charges, 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 AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT**, Paragraph F. Please read the part entitled **DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT** 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, rescind, cancel or decline to renew your Agreement.

You hereby expressly acknowledge that you understand this agreement constitutes a contract solely between you and Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Anthem to use the Blue Cross Service Mark in the State of California, and that Anthem is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this agreement based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to you for any of Anthem's obligations you created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

HOW TO CONTACT US

Anthem Blue Cross web site (www.anthem.com/ca) provides convenient online information regarding your health coverage. Within the “Members” section of our site, many of your questions can be answered quickly and easily. For instance, you can:

- Locate Participating Providers
- Check the status of your claims and download claim forms
- Access premium health content and tools from Subimo™ and WebMD®.
- Review your health plan's benefits
- Learn about Pharmacy benefits and your plan's Health Programs

If you want secure access to all the features the web site has to offer, simply log on to www.anthem.com/ca, select “Members” and follow the prompts for registering. You will need your member ID number, which is located on your health card.

For information about...	Contact	Phone Number	Address
Enrollment	Membership	(800) 333-0912	Anthem Blue Cross P.O. Box 9051 Oxnard, CA 93031-9051
Medical Claims and Benefits	Claims	(800) 333-0912	Anthem Blue Cross P.O. Box 6007 Los Angeles, CA 90060-0007
HealthyCheck	Customer Service	(800) 274-WELL (9355)	www.anthem.com/ca
Participating Providers in California	Customer Service	(800) 333-0912	www.anthem.com/ca
Providers outside California	BlueCard Program	(800) 810-BLUE (2583)	www.bcbs.com
Spanish Customer Service	Customer Service	(800) 226-3714	www.nuestrobien.com/
Chinese Customer Service	Customer Service	(888) 951-9633	www.chinese.anthem.com/
Korean Customer Service	Customer Service	(800) 333-0912	www.korean.anthem.com/
Hearing and Speech Impaired Customer Service	Customer Service	TTY (877) 206-4966	
Preservice Review	Medical Care Management	(800) 274-7767	
Pharmacy (Retail Pharmacy and Prior Authorization)	Pharmacy Benefits Manager	(800) 700-2533	Anthem Blue Cross Prescription Drug Program P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (Mail Service)	Pharmacy Benefits Manager	(866) 274-6825	Anthem Blue Cross Mail Service Prescription Drug Program P.O. Box 961025 Fort Worth, TX 76161-9863 P.O. Box 746000 Mason, OH 45274 www.anthem.com/ca
Pharmacy (SpecialtyRx)	Pharmacy Benefits Manager	(800) 870-6419	Pharmacy Benefits Manager 2825 W. Perimeter Suite 116 Indianapolis, IN 46241 www.anthem.com/ca

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

- *Recognizing and respecting you as a member.*
- *Encouraging your open discussions with your health care professionals and providers.*
- *Providing information to help you become an informed health care consumer.*
- *Providing access to health benefits and our network providers.*
- *Sharing our expectations of you as a member.*

Member rights. you have the right to:

- Be treated with respect and dignity.
- Receive benefits for which you have coverage.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Participate with your health care professional and providers in making decisions about your health care.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Participate in matters of the organization's policy and operations.

As a member, you have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Evidence of Coverage and Disclosure Form and not by this Member Rights and Responsibilities statement.

ELIGIBILITY

Who is Eligible for Coverage

The **Subscriber** is the person listed as the applicant whose Individual Enrollment Application has been approved and accepted by us for coverage under this Agreement.

Family Members are the following Members of the Subscriber's family who are eligible and accepted under this Agreement:

- The Subscriber's lawful spouse.
- The Subscriber's Domestic Partner, subject to the following:
The Subscriber and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code. The Domestic Partner does not include any person who is covered as a Subscriber or Spouse.
- Any children of the Subscriber or the Subscriber's enrolled spouse or enrolled Domestic Partner will be eligible to enroll and remain covered until the last day of the calendar month in which they turn 26.
- Limiting Age is when your dependent does not continue to meet the qualifications to remain as a dependent on your plan. Upon reaching the Limiting Age, Anthem will automatically enroll your dependent, if a resident of California, on the same Plan, under his/her own identification number.

Overage Dependents

- Any of the Subscriber's, enrolled Spouse's or enrolled Domestic Partner's children who are incapable of self-sustaining employment due to a continued physically or mentally disabling injury, illness, or condition and who are dependent upon the Subscriber, the enrolled Spouse or enrolled Domestic Partner for support.
 - Ninety (90) days before the dependent child reaches the limiting age, Anthem will issue a request for proof that the dependent child meets the criteria for continued coverage.
 - The Subscriber must submit written proof of such dependency within sixty (60) days of receiving the request.
 - Before the date the dependent child reaches the limiting age, Anthem will determine whether the dependent child meets the criteria for continued coverage.
 - Two years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.
 - Anthem may request a new Subscriber to provide information regarding a dependent child with a physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the dependent child meets the criteria for continued coverage. The Subscriber must submit written proof of such dependency within sixty (60) days of receiving the request.

Newborns and Adopted Children

- Newborns of the Subscriber or the Subscriber's enrolled spouse or enrolled Domestic Partner are automatically enrolled for the first thirty-one (31) days of life. TO CONTINUE COVERAGE FOR A NEWBORN BEYOND THE FIRST THIRTY ONE (31) DAYS OF LIFE, YOU MUST NOTIFY ANTHEM IN WRITING WITHIN THIRTY-ONE (31) DAYS OF BIRTH. THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.
- NEWBORNS OF THE SUBSCRIBER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS AGREEMENT.
- A child being adopted by the Subscriber will be automatically enrolled for 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 Subscriber, the 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 ADOPTED CHILD YOU MUST NOTIFY US IN WRITING WITHIN THIRTY-ONE (31) DAYS OF THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM

THE DATE THE SUBSCRIBER'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 Agreements that have been rescinded, eligible Subscribers on such Agreements may continue coverage, without medical underwriting, in one of the following ways:

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

In either instance, subscription charges may be revised to reflect the number of persons on the Agreement.

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

If a Member was subject to a Pre-existing Condition exclusion on a rescinded Agreement and continues coverage after the rescission of an Individual Agreement, the Member may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded Agreement. This means that we will credit any time that the eligible Member 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.

When the Member Becomes Ineligible

A Member becomes ineligible for coverage under this Agreement when and subject to termination pursuant to the part entitled "DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY":

1. The Subscriber does not pay the subscription charges when due.
2. The spouse is no longer married to the Subscriber.
3. The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.
4. Coverage for a dependent child ends on the last day of the month in which the dependent child reaches age 26.
5. A Member moves to and lives in a place outside of California.
6. The Member fails to cancel any other coverage upon becoming enrolled under this Agreement.

Notice of Change in Eligibility

You must notify us of all changes affecting any Member's eligibility under this Agreement within thirty (30) days of the change. You should address any written notice to us at Anthem Blue Cross, P.O. Box 9051 Oxnard, California 93031-9051.

Options in the Event of Changed Circumstances

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

Family Members who lose eligibility for coverage under this Agreement may apply for their own coverage.

If your Family Member does not meet the qualifications to remain as a Family Member on your Agreement Anthem will automatically enroll your Family Member, if a resident of California, on the same Agreement 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. You should address any written notice to us at Anthem Blue Cross, P.O. Box 9051 Oxnard, California 93031-9051.

SERVICES, BENEFITS AND SUBSCRIPTION CHARGES UNDER A MEDICARE SUPPLEMENT WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS AGREEMENT.

MAXIMUM COMPREHENSIVE BENEFITS

If within the same calendar Year, a Member replaces any Anthem individual medical Plan with another Anthem individual medical Plan, any benefits applied toward the Deductible, Yearly Maximum Copayment/Coinsurance Maximums or any benefit maximums of that prior Plan will be applied toward the Deductible, Yearly Copayment/Coinsurance Maximum or any benefit maximums of this Plan.

Any additional limits on the number of visits or days covered are stated in the PARTS entitled, BENEFIT COPAYMENT/COINSURANCE LIST and/or COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Deductible

Before we pay for any medical benefits, you must satisfy your \$7,500 Yearly Deductible per Member. The first two (2) Members of an enrolled family to satisfy their individual Deductibles in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. However, we will not credit any Deductible over and above the family Deductible maximum that was applied but did not satisfy an individual Member's Deductible amount in full. The medical Deductible is described in the following part entitled BENEFIT COPAYMENT/COINSURANCE LIST.

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.

Copayments/Coinsurance

You will be required to pay a Copayment/Coinsurance for services received while you are covered under this Plan. Your Copayment/Coinsurance may be a fixed dollar amount per day, per visit or it may be a percentage of eligible charges. It could also be a combination of a fixed dollar amount and a percentage of eligible charges. Hospital admission charges and some Copayments/Coinsurance (e.g., all charges in excess of the Negotiated Fee Rate when using a Non-Participating Provider, Copayments for not obtaining Preservice Review) **will not** be applied toward your Yearly Maximum Copayment/Coinsurance Limit and **will continue to be required** even after your Yearly Maximum Copayment/Coinsurance Limit has been reached. **Refer to the part entitled BENEFIT COPAYMENT/COINSURANCE LIST to determine your Copayment/Coinsurance responsibility for Covered Services for Participating and Non-Participating Providers.**

Yearly Maximum Copayment/Coinsurance Limit

The Yearly Maximum Copayment/Coinsurance Limit for **Participating/Preferred Participating and/or Non-Participating Providers**, also referred to as the out of pocket maximum, is **\$7,500** per Member per Year. For a family, when two (2) Members of an enrolled family have met their Yearly Maximum Copayment/Coinsurance Limit, no further Copayment/Coinsurance will be required for Participating/Preferred Participating and/or Non-Participating Providers for the remainder of that Year.

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

Your Yearly Deductible for Covered Services will apply towards your Yearly Maximum Copayment/Coinsurance Limit.

Exception: Amounts you pay for the following services rendered by either Participating or Non-Participating Providers will **not** accumulate toward satisfying your Yearly Maximum Copayment/Coinsurance Limit and you will continue to be required to pay Copayments/Coinsurance for those services even after your Yearly Maximum Copayment/Coinsurance Limit has been reached: Acupuncture and Acupressure, and services under the benefit entitled, Mental or Nervous Disorder and Substance Abuse (other than Severe Mental Illness and Serious Emotional Disturbances of a Child). Amounts you pay for Physical Therapy, Occupational Therapy and Chiropractic Care services rendered by Non-Participating Providers will not apply to your Yearly Maximum Copayment/Coinsurance Limit and you will continue to be required to pay Copayments for these services even after your Yearly Maximum Copayment/Coinsurance Limit has been reached.

Note: You will continue to be responsible for amounts over our allowed payment for the above listed services rendered by either a Participating or Non-Participating Provider.

In addition, Hospital admission charges, all charges in excess of the Negotiated Fee Rate when using a Non-Participating Provider, Prescription Drug Copayments and Copayments for not obtaining Preservice Review will **not** accumulate toward satisfying your Yearly Maximum Copayment/Coinsurance Limit and will continue to be required even after your Yearly Maximum Copayment/Coinsurance Limit has been reached.

BENEFIT COPAYMENT/COINSURANCE LIST

For a detailed description of what is covered, see the part entitled, COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Your Deductible each Year for services is \$7,500 per Member. During each Year, each Member is responsible for all expense incurred for Covered Services up to the Deductible amount. This amount must be recorded on our files as payable by the Member to the provider of service. 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. The first two (2) Members of an enrolled family to satisfy their individual Deductibles in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. However, we will not credit any Deductible over and above the family Deductible maximum that was applied but did not satisfy an individual Member's Deductible amount in full.

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.

Your Yearly Deductible for Covered Services **will** apply towards your Yearly Maximum Copayment/Coinsurance Limit. Once you have satisfied your Yearly Maximum Copayment/Coinsurance Limit Anthem will pay 100% of Covered Services for the remainder of that year.

If you submit a claim for services which have a maximum payment limit (e.g., Physical Therapy, Occupational Therapy and Chiropractic Care performed by a Non-Participating Physician, or Skilled Nursing Facility at a Non-Participating or out of state Facility) and your Deductible is not satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible amount.

Note: No Deductible is required for all covered Office Visits, Acupuncture and Acupressure, Well Baby and Well Child Office Visits or Preventive Care Office Visits.

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 Agreement for Non-Participating Providers. See the **Special Circumstances** section of this Provider Copayment/Coinsurance List for situations that may reduce your payment responsibility when utilizing a Non-Participating Provider.

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

INPATIENT HOSPITAL

Preferred Participating Hospital

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Participating Hospital

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** \$500 admission charge.*

Non-Participating Hospital

All charges in excess of \$650 per day unless **Special Circumstances** apply.

A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only at a CME, except for Medical Emergencies. For more information, please see the section entitled Center of Medical Excellence (CME) for Transplants and Bariatric Surgery under the part entitled Comprehensive Benefits: What Is Covered By Anthem.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

OUTPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTERS

Preferred Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** \$500 admission charge* when the visit is related to surgery or Infusion Therapy.

Non-Participating Provider

All charges in excess of \$380 per day unless **Special Circumstances** apply.

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

EMERGENCY ROOM In a Medical Emergency or Accident

Preferred Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Emergency Room services in the state of California, for both Participating and Non-Participating Providers are subject to an additional \$100 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

EMERGENCY ROOM In a Non-Medical Emergency or Non-Serious Accidental Injury

Preferred Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

All charges in excess of \$380 per day unless **Special Circumstances** apply.

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

SKILLED NURSING FACILITY

This does not include treatment for Mental or Nervous Disorders or Substance Abuse (**except for the treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child**). Limited to 100 days per Year combined for Participating and Non-Participating Providers.

Participating Skilled Nursing Facility

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating and Out of State

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

HOME HEALTH CARE SERVICES

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

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

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

PROFESSIONAL SERVICES

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

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

OFFICE VISITS

Participating Provider

\$40 per Office Visit

Non-Participating Provider

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

MEDICAL SUPPLIES AND EQUIPMENT

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

FOOTWEAR

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

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate.

AMBULANCE

IN A MEDICAL EMERGENCY OR WITH AN AUTHORIZED REFERRAL

Participating Provider

Ground Ambulance: No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Air Ambulance: No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

Ground Ambulance:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Air Ambulance:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

AMBULANCE

OTHER THAN IN A MEDICAL EMERGENCY OR WITHOUT AN AUTHORIZED REFERRAL

Participating Provider

Ground Ambulance:

30% of the Negotiated Fee Rate.

Air Ambulance:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

Ground Ambulance:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate.

Air Ambulance:

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

DENTAL INJURY

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

INFUSION THERAPY

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

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.

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 **plus** all charges in excess of the per day maximum payment indicated above.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY and/or CHIROPRACTIC CARE

Non-Participating Provider payments for these benefits will not be applied to the Member's Yearly Maximum Copayment/Coinsurance Limit. Members may receive these services up to 24 visits per Year combined for Participating and Non-Participating Providers. Additional visits will be covered as authorized by Anthem, but only if Anthem determines that additional treatment is Medically Necessary. Anthem will authorize a specific number of additional visits.

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

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

ACUPUNCTURE and ACUPRESSURE

Limited to 24 visits per Year combined for Participating and Non-Participating Providers. Payments for this benefit will not be applied toward the Yearly Member's Maximum Copayment/Coinsurance Limit. No Deductible is required.

Participating Provider

All of the Negotiated Fee Rate except, \$30 per visit.

Non-Participating Provider

All charges **except** \$30 per visit.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

PREGNANCY and MATERNITY CARE

Hospital charges are paid as any other illness. Refer to the Inpatient Hospital section of this BENEFIT COPAYMENT/COINSURANCE LIST.

Professional Charges

Participating Physician

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Physician

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the Negotiated Fee Rate.

WELL BABY and WELL CHILD CARE

Participating Provider

0% of the Negotiated Fee Rate.

Non-Participating Provider

50% of the Negotiated Fee Rate for the Office Visit and all other Covered Services related to that visit **plus** all charges in excess of the Negotiated Fee Rate.

PREVENTIVE CARE SERVICES

Participating Provider

0% of the Negotiated Fee Rate.

Performed at HealthyCheck Centers

0% of the Negotiated Fee Rate.

Non-Participating Providers

All charges in excess of 50% of the Negotiated Fee Rate.

PHYSICAL EXAM (Including Office Visit)

Participating Provider

0% of the Negotiated Fee Rate

Non-Participating Provider

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

MENTAL or NERVOUS DISORDERS and SUBSTANCE ABUSE

Except for the treatment of Severe Mental Illness 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. The payments for this benefit will not be applied toward the Member's Yearly Maximum Copayment/Coinsurance Limit. Benefits are provided up to a maximum number of days per year as indicated below, Participating and Non-participating Providers combined.

Inpatient Hospital and Day Treatment Program

Participating or

Preferred Participating Providers

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible. Limited to 30 days per Year. After 30 days, you pay all charges for the remainder of that Year.

Non-Participating Provider

50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply. Limited to 30 days per Year. After 30 days, you pay all charges for the remainder of that Year.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

MENTAL or NERVOUS DISORDERS and SUBSTANCE ABUSE continued

Professional Services

(Inpatient and Outpatient Physician Services)

Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible. Limited to 1 visit per day and 20 visits per Year.

Non-Participating Provider

50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply. Limited to 1 visit per day and 20 visits per Year.

SEVERE MENTAL ILLNESS and SERIOUS EMOTIONAL DISTURBANCES of a CHILD

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

SMOKING CESSATION PROGRAM

Participating Providers and
Non-Participating Providers

We will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. Anthem pays 100% of the Negotiated Fee Rate.

FOREIGN COUNTRY PROVIDERS

For initial treatment of a Medical Emergency only.

All Providers

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

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

OTHER ELIGIBLE PROVIDERS

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, an audiologist, a respiratory therapist.

All Providers Listed Above

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

SPECIAL CIRCUMSTANCES

Authorized Referral

Non-Participating Hospital
(inpatient or outpatient)
Physician, Ambulatory Surgical Center

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

For Medical Emergencies Within California

Your payment responsibility for Covered Services received from Non-Participating Providers, including Ambulance, will be at the Participating percentage for emergency services as described below.

Emergency Room services for both Participating and Non-Participating Providers are subject to an additional \$100 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

Non-Participating Providers

Physician:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

Hospitals and Non-Contracting Hospitals:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

Ambulatory Surgical Centers:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

Ambulance:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

BLUECARD PROGRAM

FOR MEDICAL EMERGENCIES OUTSIDE OF CALIFORNIA

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the **BlueCard Program**, in which we participate, which allows our Members 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. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912.

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

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

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

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating Subscriber 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 Subscriber liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph four 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 Members 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 Members 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 PPO 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

YOUR PAYMENT RESPONSIBILITY

MEDICAL NON-EMERGENCIES OUTSIDE OF CALIFORNIA

Physician

PPO Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Traditional Provider*

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of the BlueCard Negotiated Price.

Hospital or Ambulatory Surgical Center

PPO Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Traditional Provider*

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

Hospital Inpatient:

You pay all charges in excess of \$650 per day.

Hospital Outpatient:

You pay all charges in excess of \$380 per day.

Ambulatory Surgical Centers:

You pay all charges in excess of \$380 per day.

* If there are no PPO Providers in the area you will have no Coinsurance for the remainder of that year after you have satisfied your Yearly Deductible.

MEDICAL EMERGENCIES OUTSIDE OF CALIFORNIA

Your payment responsibility, for Covered Services received from Non-Participating Providers, including Ambulance, will be at the Participating percentage for emergency services as described below.

Physician

PPO Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Traditional Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

Hospital or Ambulatory Surgical Center

PPO Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Traditional Provider

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible.

Non-Participating Provider

Hospital:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

Ambulatory Surgical Centers:

No Coinsurance required for the remainder of that year after you have satisfied your Yearly Deductible **plus** all charges in excess of Customary and Reasonable.

COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM

Before we pay for any benefits, you must satisfy your Deductible. The medical Deductible is described in the preceding part entitled BENEFIT COPAYMENT/COINSURANCE LIST.

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

Described below are the types of services covered under this Agreement 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 CHARGES. Knowing the meaning of these terms will greatly assist you in determining the benefits of this Agreement and your Copayment/Coinsurance responsibility.

Another term you should become familiar with is “Preservice Review.” Preservice Review begins when your Physician provides medical information to us prior to a specific service or procedure is 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 Services (requires Preservice Review except for delivery of a Child or 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.
- Care 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 including oxygen given to you during your stay.
- 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.

Skilled Nursing Facilities

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

- A room with two or more beds.
- Special treatment rooms.
- Laboratory tests.
- Physical therapy, occupational therapy, speech therapy, oxygen and other respiratory therapy.
- Drugs and medicines given to you during your stay.

Professional Services and Supplies

- Services of a **Physician** including surgeons and specialists.
- Services of an **anesthesiologist or anesthesiologist**.
- Outpatient **speech therapy** when following surgery, injury or otherwise as Medically Necessary. Members may receive these services up to 50 visits per Year. Additional visits will be covered when authorized by Anthem, but only if Anthem determines that additional treatment is Medically Necessary. Anthem will authorize a specific number of additional visits.

- 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
- FDA-approved **cancer screenings** including an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, ovarian and cervical cancer screening tests, including the human papilloma virus (HPV) test for cervical cancer, prostate specific antigen (PSA) testing, and the Office Visit related to these services. These services are provided at your Physician's office and not at the HealthyCheck centers.
- **Human Immunodeficiency Virus (HIV) testing**, regardless of whether the testing is related to a primary diagnosis.
- **Prosthetic devices** related to a laryngectomy.
- **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.
- **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.
- **Physical Therapy, Occupational Therapy and/or Chiropractic Care** visits, when rendered by a Physician. Members may receive these services up to 24 visits per Year combined for Participating and Non-Participating Providers.
Members may receive these services in additional visits authorized by Anthem, but only if Anthem determines that additional treatment is Medically Necessary. Anthem will authorize a specific number of additional visits.
- **Footwear** services in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness.
- **FDA approved medications** that may only be dispensed by or under direct supervision of a Physician.
- **Genetic testing** and diagnostic procedures for Members when Medically Necessary to treat an inheritable disease.
- **Injectable contraceptives**, except Norplant, when administered in a Physician's office.
- **Hepatitis B and varicella zoster** (chicken pox) vaccines for Members age 7 through 18 and the Office Visit associated with administering that vaccination when ordered by your Physician.
- **Reconstructive surgery** performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function; or create a normal appearance, to the extent possible.
- **Ambulance service** (i.e. base charge, mileage and non-reusable supplies) to transport you to or from a Hospital or Skilled Nursing Facility when Medically Necessary. Payment of benefits for ambulance services may 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 you 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.

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 Agreement. 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.

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. 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.

Covered under this benefit are inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

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 part entitled EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY ANTHEM.

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

Wigs

We will pay up to \$400 per Member per Year with a Physician Prescription.

Dental

- Up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.
- Services of a Physician or Dentist treating an accidental injury to your natural teeth when you receive treatment within one year following the injury, except orthodontia. 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 Members:
 - Under seven (7) years of age.
 - Developmentally disabled, regardless of age.
 - Whose health is compromised and general anesthesia is Medically Necessary, regardless of age.

Pregnancy and Maternity Care

- Doctor visits for prenatal and postnatal care and genetic testing.
- Routine nursery care for a newborn.
- Hospital services in connection with a pregnancy and inpatient Physician services for normal delivery, cesarean section and complications of pregnancy.

The mother and her newborn shall be entitled to Inpatient Hospital coverage for a period of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section. The decision to discharge the mother and newborn before the 48 or 96 hour time period can only be made by the treating Physician in consultation with the mother. If the mother is discharged early, then the mother and newborn will be covered for a post-discharge follow-up visit within 48 hours of the discharge when prescribed by the treating Physician.

Please call us at 1-800-769-4896 within the first twelve (12) weeks of your pregnancy to notify us of your estimated date of delivery, your Physician's name, and the name of the Hospital you have chosen for delivery of your child.

Well Baby and Well Child Care

- Childhood immunizations and the routine physical examination associated with the immunization.
- Medically appropriate radiology services, laboratory tests and procedures in connection with the examination.
- Routine hearing and vision tests.

Preventive Care

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Allowable Charge. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force;
Examples of these services are screenings for:
Breast cancer;
Cervical cancer;
Colorectal cancer;
High Blood Pressure;
Type 2 Diabetes Mellitus;
Cholesterol;
Child and Adult Obesity.
2. Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

You may call Customer Service using the number on your ID card for additional information about these services.

HealthyCheck Centers (For Members age 7 to adult)

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

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

Covered Preventive Care Services also include the following services required by state and federal law: The following services available only at HealthyCheck Centers:

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

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

For adults only:

- Cholesterol: Total and HDL (“good”)
- Glucose

For children only:

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

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

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

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition. Benefits and services will be considered under the Diagnostic Services benefit.

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:

1. The following 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 plan’s benefits for durable medical equipment (See Medical Supplies and Equipment).

2. Diabetes Outpatient Self-Management Training Program which:

- Is designed to teach a Member who is a patient, and covered Members 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 Member to properly use the equipment, supplies, and medications necessary to manage the disease; and
- Is supervised by a Physician.

Diabetes education services are covered under plan benefits for professional services by Physicians.

3. The following items are covered under your Prescription Drug benefits:

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

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

Phenylketonuria (PKU)

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

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

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

1. Prescribed by a Physician or nurse practitioner for the treatment of phenylketonuria (PKU) and
2. Is consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of, phenylketonuria (PKU).
3. 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.

Mental or Nervous Disorders and Substance Abuse, including Treatment for Severe Mental Illness and a 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.

Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness 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.

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").

Cancer Clinical Trials

If a Member is diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, Anthem will cover all routine patient care costs related to the clinical trial on the same basis as any other medical condition if the Member's treating Physician, who is providing the health care services to the Member under this Agreement recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member. The clinical trial must have a therapeutic intent and not just be to test toxicity. Coverage for clinical trials is restricted to Participating Providers in California, unless the protocol for the clinical trial is not provided for at a California Hospital or by a California Physician.

Benefits are paid on the same basis as any other medical condition and are subject to any applicable Copayments, Coinsurance and Deductibles. In the case of Covered Services for a clinical trial provided by a Non-Participating Provider, Anthem will pay based on the Negotiated Fee Rate subject to the applicable

Copayments, Coinsurance and Deductibles. However, the Member will be responsible for charges in excess of the Negotiated Fee Rate.

The treatment provided in a clinical trial must either:

1. Involve a Drug that is exempt under federal regulations from a new Drug application or
2. 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, including:

- 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 a Member may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or services that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Agreement.
- Health care services customarily provided by the research sponsors free of charge to Members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-Covered Services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Independent Medical Review as described in the part entitled GRIEVANCE PROCEDURES.

Center of Medical Excellence (CME) for Transplants and Bariatric Surgery (requires Preservice Review)

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

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

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

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a

CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures. **Preservice Review can be obtained by calling toll free 1-800-274-7767.** When you or your Physician calls for the required Preservice Review, we will advise you that such services must be performed at an Anthem Blue Cross CME.

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

Bariatric Travel Expense: The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Member'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 Member to and from the CME up to \$130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the CME up to \$130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Member 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 Member'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.

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

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

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

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

- the recipient or
- the donor.

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

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

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's place of residence.

- Lodging, limited to one room, double occupancy. Meals, tobacco, alcohol, drug expenses and other non-food items are excluded.

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

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

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

Unrelated Donor Searches

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

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

Smoking Cessation

We will cover smoking cessation programs designed to end the dependence on nicotine as determined by federal and state law. Covered benefits apply to in network services only. Anthem pays 100% of the Negotiated Fee Rate

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 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 unreplaced 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. No separate benefit is provided for these services and supplies. These services and supplies are included in the charges for the Drugs and durable medical equipment used.
- 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. The 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. The Member will be responsible for any charges in excess of the Average Wholesale Price of a Drug for Non-Participating Providers.

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

Home Health Care

A Physician must order the Home Health Care and renew the order at least once every thirty (30) days. Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association. Limited to 60 visits per Year for Participating and Non-Participating Providers combined.

A visit is defined as 4 hours or less of service provided by one of the following providers:

- A registered nurse;
- A licensed therapist for physical, occupational, speech or respiratory therapy;
- A medical social service worker;
- Services of a health aide employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. A health aide is covered only if you’re also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services.
- Private Duty Nursing when Medically Necessary and approved by Anthem.

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.

EXCLUSIONS AND LIMITATIONS: WHAT IS NOT COVERED BY ANTHEM

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.

Contraceptive Drugs or devices including Norplant and Norplant kits except injectable contraceptives when administered by a Physician, and except as specifically outlined under the part entitled YOUR PRESCRIPTION DRUG BENEFITS and except an alternate FDA approved contraception method requiring a Physician's Prescription required because of your medical condition.

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

Custodial Care: Custodial care is care that does not require the 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. Domiciliary, or rest cures for which facilities, and/or services of a general acute Hospital are not medically required including resident treatment centers are also excluded.

Dental Services: Dentures, bridges, crowns, caps, clasps, habit appliances, partials, or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated for Dental Care under the benefits section of this Agreement. **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.

Educational, Vocational, and Training Services except as specifically listed as being covered under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the part entitled BENEFIT COPAYMENT/COINSURANCE LIST of this Agreement.

Experimental: Any medical, surgical and/or other procedures, services, products, Drugs or devices including implants, whose use is mainly limited to laboratory and/or animal research except as specifically stated under Clinical Trials in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM. Anthem has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a covered service because it is experimental, a Member may request an Independent Medical Review. Refer to the part entitled GRIEVANCE PROCEDURES.

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

Genetic Testing for non-medical reasons or when there is not medical indication or no family history of genetic abnormality.

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

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

Hearing Aids and Routine Hearing Tests: Routine hearing tests except where provided for under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM under Well Baby and Well Child Care and/or Preventive Care.

Infertility Treatment: Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Investigational: Any medical, surgical and/or other procedures, services, products, Drugs or devices (including implants) except as specifically stated under Clinical Trials in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM: (a) which do not have final approval from the appropriate governmental regulatory body; or (b) which are not supported by scientific evidence which permits conclusions concerning the effect of the service, Drug or device on health outcomes; or (c) which do not improve the health outcome of the patient treated; or (d) which are not as beneficial as any established alternative; or (e) whose results outside the investigational setting cannot be demonstrated or duplicated; or (f) which are not generally approved or used by Physicians in the medical community. Anthem has discretion to make this determination. However, if a Member has a life-threatening or seriously debilitating condition and Anthem determines that requested treatment is not a covered service because it is investigational, a Member may request an Independent Medical Review. Refer to the part entitled GRIEVANCE PROCEDURES.

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 Agreement. **However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with Mental or Nervous conditions (e.g., self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, except as described in the part entitled BENEFIT and COPAYMENT/COINSURANCE LIST in this Agreement.

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 Agreement, except as follows:

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

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

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

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

Not Medically Necessary: Any services or supplies that are: a) not Medically Necessary, b) not specifically described in this Agreement and part of a treatment plan for non-Covered Services or c) costs of routine follow-up care for non-Covered Services (as recognized by the organized medical community in the State of California) (but we will provide benefits for Medically Necessary covered services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.).

Nutritional Counseling, except Diabetes.

Outdoor Treatment Programs

Outpatient Speech Therapy, except following surgery, injury, or otherwise as Medically Necessary.

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

Pre-existing Conditions: For Members age 19 and older 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. If you were covered under Creditable Coverage within 62 days of becoming covered under this Agreement, the time spent under the Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period. No pre-existing waiting period for any conditions for any Member under the age of 19.

Private Duty Nursing: Except as expressly provided under the section entitled, Home Health Care in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

Routine Physical Exams except as outlined under section entitled Preventive Care in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM. Routine physical exams or tests except when performed at one of our HealthyCheck Centers.

Services For Which You Are Not Legally Obligated To Pay: Services for which you have no legal obligation to pay or for which no charge would be made if you did not have 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 Member's home or who is related to the Member by blood, marriage or adoption.

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

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 Changes.

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 this Agreement in connection with a surrogate pregnancy (including but not limited to, the bearing of a child by another woman for an infertile couple).

Telephone and Facsimile Consultations: Consultations provided by telephone or facsimile machines.

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.

Unlisted Services: Services not specifically listed in this Agreement 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 Agreement. **Certain Eye Surgeries:** 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, treatment of obesity, or any care which involves weight reduction as a 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 Center 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.

YOUR PRESCRIPTION DRUG BENEFITS

Benefits are provided as follows for Prescription Drugs purchased from licensed retail Pharmacies by Members eligible to receive outpatient Prescription Drug benefits under this Combined Evidence of Coverage and Disclosure Form.

Anthem Blue Cross uses a preferred list of Drugs, sometimes called a Formulary, to help your doctor make prescribing decisions. This list of Drugs is updated quarterly by a committee consisting of independent doctors and pharmacists so that the list includes Drugs that are safe and effective in the treatment of disease. The presence of a drug on the plan's formulary does not guarantee that it will be prescribed. If you have a question regarding whether a Drug is on the Anthem Preferred Drug List, please call the Pharmacy Benefits Manager toll free at 1-800-700-2533 or access information on our web site at www.anthem.com/ca.

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

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

Amounts we allow for Prescription Drugs obtained from Non-Participating Pharmacies are usually significantly lower than what those providers customarily charge, so you will almost always have a higher out-of-pocket expense for Drugs when you use a Non-Participating Pharmacy to fill your Prescription.

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: WHAT IS NOT COVERED BY ANTHEM.

Definitions

Compound Medication is a mixture of prescription drugs and other ingredients, of which at least one of the components is commercially available as a prescription product. Compound Medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
2. Products lacking an NDC number.

All claims for reimbursement for Compound Medications must be submitted electronically (by the pharmacy) and will be paid at the Prescription Drug Maximum Allowed Amount. Compound Medications may be limited to distribution at designated pharmacies.

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

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

Maintenance Prescription Drugs are Prescription Drugs which are taken for an extended period of time to treat a medical condition.

Non-Participating Pharmacy is a Pharmacy which 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.

Participating Pharmacy is a Pharmacy which has a Participating Pharmacy Agreement in effect with or for the benefit of Anthem at the time services are rendered. Call your local Pharmacy or call customer service at 1 800 700-2533. Some Participating Pharmacies display a 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 Blue Cross using cost information provided to Anthem Blue Cross 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.

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

Tier Drugs may vary based on whether the Prescription Drug has been classified by Us as a first or second tier drug. The determination of tiers is made by Us is based upon clinical information, and where appropriate the cost of the drug relative to other drugs in is therapeutic class or used to treat the same or similar condition, the availability of over-the counter alternatives; and where appropriate certain clinical economic factors.

- **Tier 1** drugs have the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.
- **Tier 2** drugs will have a higher copayment than those in Tier 1. This Tier will contain preferred medications, including specialty drugs that generally are moderate or high in cost. This Tier may include generic, single source, or multi-source brand drugs.

Your Prescription Drug benefits are as follows:

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

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

PRIOR AUTHORIZATION

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

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

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

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

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

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

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

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

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

If prior authorization of a Drug is not approved, you or your prescribing Physician may appeal our decision by calling us at 1-800-700-2533. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the part entitled GRIEVANCE PROCEDURES.

Revoking or modifying a prior authorization

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

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

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

Tier 2 and Specialty Prescription Drug Deductible

Each Member must meet a Prescription Drug Deductible amount of \$750 each Year. This Deductible is separate from the annual Deductible for medical benefits and does not accumulate towards satisfying the medical Yearly Maximum Copayment/Coinsurance Limit. This Prescription Drug Deductible applies to all prescriptions, EXCEPT Tier 1 Prescription Drugs, purchased through the Mail Order Prescription Drug Program and at Participating and Non-Participating Pharmacies combined. However, any Copayment made for a Tier 2 Prescription Drug that has been specified by your Physician to “dispense as written” or “do not substitute” when a Tier 1 equivalent exists, the Prescription Drug Maximum Allowed Amount for that Tier 2 Drug will **not** be applied towards the Prescription Drug Deductible. The first two (2) Members of an enrolled family to satisfy their Prescription Drug Deductible in full will satisfy this Deductible for the entire family. Once the family Prescription Drug Deductible is satisfied, no further Prescription Drug Deductible is required for the remainder of that Year. However, we will not credit any Prescription Drug Deductible over and above the family Prescription Drug Deductible maximum that was applied but did not satisfy an individual Member’s Prescription Drug Deductible amount in full.

TIER 2 AND SPECIALTY PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

There is a \$4,250 Prescription Drug Out-of-Pocket Maximum for Prescription Drugs per Year purchased from Participating Pharmacies, through the mail order Prescription Drug program or through Specialty Preferred Provider. You will not be required to pay more than \$4,250 per Year for Prescription Drugs purchased from Participating Pharmacies, through the mail order Prescription Drug program or through Specialty Preferred Provider. Once the \$4,250 Tier 2 and Specialty Prescription Drug Out-of-Pocket Maximum is met, no further Coinsurance will be required for Participating Pharmacies, through the mail order Prescription Drug program or through Specialty Preferred Provider for the remainder of that Year.

What is Covered

- Outpatient Drugs and medications which Federal and/or State of California law restrict to sale by Prescription only.
- Insulin and 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.
- 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.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by Anthem and are limited to eight (8) tablets/units per 30 day period.
Not covered under Mail Order Prescription Drug Program.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Prescription Drugs and the Prescription Drug Deductible.

Note: Tier 1 Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Tier 2 Drug and states “Dispense as written” or “Do not substitute” or no Tier 1 equivalent exists. However, any Copayment made for a Tier 2 Drug that has been specified by your Physician to “dispense as written” or “do not substitute” when a Tier 1 Drug equivalent exists, the Prescription Drug Maximum Allowed Amount for that Tier 2 Drug will **not** be applied towards the Prescription Drug Deductible.

Conditions of Service

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program, or through our Specialty Preferred Provider within one year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration.
- Be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Not be used while the Member is an inpatient in any facility.
- Be dispensed by a participating pharmacy if it is an approved compound medication. You may call 1-800-700-2541 or go to our website www.anthem.com/ca to find out where to take your prescription for an approved compound medication to be filled. All claims for reimbursement for Compound Medications must be submitted electronically (by the Pharmacy) and will be paid at the Prescription Drug Maximum Allowed Amount.

Note: Some compound medications must be approved before you can get them. You will have to pay the full cost of the compound medications that you get from a pharmacy that is not a participating pharmacy.

- Be dispensed by the Specialty Preferred Provider if it is a specialty drug. See the section Specialty Pharmacy Program in this part for information on how to obtain specialty drugs through the Specialty Preferred Provider.

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

The Prescription must not exceed a 30-day supply unless ordered by mail through the Mail Order Prescription Drug Program, in which case the limit is a 60-day supply.

When you go to a Participating Pharmacy

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

For Drugs on the Anthem Prescription Drug Formulary:

- Tier 1 Prescription Drugs: \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater per Prescription order.
 - Tier 2 Prescription Drugs: 100% of Prescription Drug Maximum Allowed Amount per Member (two (2) Member family maximum) per Year until the \$750 Tier 2 and Specialty Prescription Drug Deductible has been satisfied. After the \$750 per Member Prescription Drug Deductible** has been satisfied:
 - \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for the Tier 2 Drug if a Tier 1 equivalent is not available.
- If you purchase a Tier 2 Drug when a Tier 1 equivalent is available, you will pay the Copayment for the Tier 1 Drug **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 2 and the Tier 1 equivalent.*
- Compound Medications: \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater. Compound Medications are subject to the Tier 2 and Specialty Prescription Drug Deductible.
 - Self Administered Injectable Drugs: 30% of the Prescription Drug Maximum Allowed Amount for Self-administered injectable Drugs and any combination kit or package containing both oral and Self-Administered Injectable Drugs, except Insulin.

For Drugs not on the Anthem Prescription Drug Formulary:

- 100% of the Prescription Drug Maximum Allowed Amount for Tier 2 Drugs until \$750 Tier 2 Prescription Drug Deductible is satisfied
After \$750 Tier 2 Drug Deductible ** has been satisfied:
 - 50% of the Prescription Drug Maximum Allowed Amount for Tier 1 Drugs.
 - 50% of the Prescription Drug Maximum Allowed Amount for Tier 2 Drugs if a Tier 1 Equivalent is not available
 - \$15 Copayment **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 2 and the Tier 1 Equivalent for Tier 2 Drugs if a Tier 1 Equivalent is available.
- Compound Medications: 50% of the Prescription Drug Maximum Allowed Amount. Compound Medications are subject to the Tier 2 and Specialty Prescription Drug Deductible.
- 30% of the Prescription Drug Maximum Allowed Amount for Self-administered injectable Drugs, except Insulin.

To determine if a Drug is available on the formulary visit our website at www.anthem.com/ca or contact Member Services at **1-800-700-2533**.

*Note:

* There are certain drugs that currently have potential equivalency issues. These drugs are called Narrow Therapeutic Index (NTI) drugs. If you purchase an NTI drug from a Participating Pharmacy, even if a Tier 1 equivalent is available, you will be responsible for the Tier 2 copayment and your Prescription Drug Deductible. A list of applicable NTI drugs is available on our website www.anthem.com/pharmacy or by calling Pharmacy customer service at 1-800-700-2533.

** Both Formulary and Non-Formulary Tier 2 Drugs count toward the \$750 Prescription Drug Deductible.

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

When you go to a Non-Participating Pharmacy

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 to:

Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Claim forms and customer service are available by calling 1 800 700-2533. Mail the claim form with the appropriate portion completed and signed by the pharmacist to Anthem no later than 15 months after the date of dispensing.

The rate of reimbursement by Anthem:

When your Prescription is filled at a Non-Participating Pharmacy: The reimbursement will be 50% of the Prescription Drug Maximum Allowed Amount less the Copayment/Coinsurance as stated for Participating Pharmacies.

Note: There is no reimbursement for Compound Medications or Specialty Drugs obtained from Non-Participating Pharmacies; therefore, you are responsible for paying the full cost of any Compound Medications or Specialty Drugs you receive from Non-Participating Pharmacies.

When You Order By Mail

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

For Drugs on the Formulary

- Tier 1 Prescription Drugs: You pay a \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for each Prescription and/or refill for each 30-day supply or a \$30 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for up to a maximum 60-day supply.
- **Tier 2 Prescription Drugs:** After a \$750 per Member (two (2) Member family maximum) per calendar Year Tier 2 and Specialty Prescription Drug Deductible is satisfied:
 - You pay a \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for each Prescription and/or refill for each 30-day supply or a \$30 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for up to a maximum 60-day supply if a Tier 1 equivalent is not available.
 - You pay a \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater, **plus** the difference in cost between the Tier 2 and the Tier 1 equivalent for each Prescription and/or refill for each thirty (30) day supply or a \$30 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater, **plus** the difference in cost between the Tier 2 and the Tier 1 equivalent for each Prescription and/or refill for up to a maximum sixty (60) day supply if a Tier 1 equivalent is available.

***Note:** There are certain drugs that currently have potential equivalency issues. These drugs are called Narrow Therapeutic Index (NTI) drugs. If you purchase an NTI drug from a Participating Pharmacy, even if a Tier 1 equivalent is available, you will be responsible for the Tier 2 copayment and your Prescription Drug Deductible. A list of applicable NTI drugs is available on our website www.anthem.com/pharmacy or by calling Pharmacy customer service at 1-800-700-2533.

The first mail order Prescription you submit must include a completed Patient Profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Member need only the Prescription and Copayment to be enclosed. You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail service Pharmacy.

Note: Some Prescription Drugs and/or medicines are not available for purchase through the Mail Order Prescription Drug program including: Drugs not on the Formulary, Drugs and medications for the treatment of impotence and/or sexual dysfunction, injectables, including Self-administered Injectables except Insulin, and antibiotics. Please check with the Mail Order Prescription Drug Program Customer Service Department at 1-866-274-6825 for availability of the Drug or medicine.

Specialty Pharmacy Program

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

Specialty Drug Prescriptions:

You will have the following Copayment for each covered Specialty Drug Prescription and/or refill obtained through the Specialty Preferred Provider:

Tier 1 Prescription Drugs: \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater.

Tier 2 Prescription Drugs: 100% of the Prescription Drug Maximum Allowed Amount per Member (two (2) Member family maximum) per Year until the \$750 Tier 2 and Specialty Prescription Drug Deductible has been satisfied. After the \$750 per Member Prescription Drug Deductible** has been satisfied:

Tier 2 Prescription Drugs on the Anthem Prescription Drug Formulary:

- \$15 Copayment or 40% of the Prescription Drug Maximum Allowed Amount, whichever is greater for the Tier 2 Drug if a Tier 1 equivalent is not available.

If you purchase a Tier 2 Drug when a Tier 1 equivalent is available, you will pay the Copayment for the Tier 1 Drug **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 2 and the Tier 1 equivalent.*

Tier 2 Prescription Drugs not on the Anthem Prescription Drug Formulary:

- 50% of the Prescription Drug Maximum Allowed Amount for Tier 1 Drugs.
- 50% of the Prescription Drug Maximum Allowed Amount for Tier 2 Drugs if a Tier 1 Equivalent is not available
- \$15 Copayment plus the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 2 and the Tier 1 Equivalent for Tier 2 Drugs if a Tier 1 Equivalent is available.

Self Administered Injectable Drugs: 30% of the Prescription Drug Maximum Allowed Amount for Self-administered injectable Drugs and any combination kit or package containing both oral and Self-Administered Injectable Drugs, except Insulin.

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

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

When You Order Your Prescription Through the Specialty Preferred Provider.

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

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician. You or your Physician may order your specialty drug from the Specialty Preferred Provider by calling 1-800-870-6419. The first time you use the Specialty Preferred Provider, you will be asked to set up your account by completing an Intake Referral Form, which can be completed over the telephone. When you or your Physician calls the Specialty Preferred Provider, a customer service representative will guide you or your Physician through the process from placing your order to delivering your Specialty Drug to you. You will be responsible to pay any applicable Brand Name Prescription Drug Deductible, Copayment or coinsurance. Once you have met your Brand Name Prescription Drug Deductible, you will only have to pay the cost of your Copayment or coinsurance. At the time of ordering and prior to shipping, the Specialty Preferred Provider may require you to pay your applicable Brand Name Prescription Drug Deductible, Copayment and coinsurance by credit card, debit card or other forms of payment.

You or your Physician may obtain a list of specialty drugs available through the Specialty Preferred Provider or order forms by contacting customer service at the address or telephone number shown below or by accessing our website at www.anthem.com/ca.

Pharmacy Benefits Manager
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: 1-800-870-6419
Fax: 1-800-824-2642

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

Exceptions to the Specialty Pharmacy Program.

This requirement does not apply to:

1. The first two months' supply of a Specialty Drug which is available through a retail Participating Pharmacy;
2. Drugs, which, due to medical necessity, are needed urgently and must be administered to the Member immediately.

How to obtain an exception to the Specialty Pharmacy Program.

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

Urgent or emergency need of a Specialty Drug subject to the Specialty Pharmacy Program.

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

If you order your Specialty Drug through the Specialty Preferred Provider and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to make an additional Copayment.

SPECIAL PROGRAMS

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

Half-Tablet Program

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

Prescription Drug Exclusions and Limitations

IN ADDITION TO ANY LIMITATIONS ON PRE-EXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE AGREEMENT, 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.
- Prescription Drugs which have non-prescription chemical and dosage equivalents.
- Non-medicinal substances or items.
- Pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches), over the counter remedies or any Prescription product containing nicotine. While not covered under this Prescription Drug benefit, under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches) are specified as covered under the section describing benefits for “Smoking Cessation”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Contraceptive devices prescribed for birth control except as specifically stated under the section entitled What is Covered under this part entitled YOUR PRESCRIPTION DRUG BENEFITS. Also, under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, contraceptive implants and associated professional services are specified as covered under the section describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medications used to induce non-spontaneous abortions. While not covered under this Prescription Drug benefit, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are specified as covered under the section of the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Dietary Supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to treat, diagnose, prevent or cure a medical condition. However, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, formulas for the treatment of phenylketonuria are specified as covered under the section describing benefits for treatment of “Phenylketonuria”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.

- Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, health aids that are medically necessary and satisfy the definition of durable medical equipment, will be covered under the section describing benefits for “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs furnished by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility. While not covered under this Prescription Drug benefit, if you need Prescription Drugs while in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, Drugs and medicines furnished to you by a Hospital while you are a patient at a Hospital are specified as covered under the section describing benefits for services and supplies furnished by a Hospital, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, Drugs and medicines furnished to you by a Skilled Nursing Facility while you are a patient at a Skilled Nursing Facility are specified as covered under the section describing benefits for services and supplies furnished by a Skilled Nursing Facility, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
 - In a rest home, sanitarium, convalescent hospital or similar facility, drugs supplied and administered by the Member’s Physician are specified as covered under the section describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits. Other drugs that may be prescribed by a Physician for a Member in a rest home, sanitarium, convalescent hospital or similar facility, can be purchased at a Pharmacy by the Member, or a friend, relative or care giver on behalf of the Member, and in such case, benefits will be provided under this Prescription Drug benefit.
- Any Drug labeled “Caution, limited by Federal law to investigational use.” Non-FDA approved investigational Drugs or any Drug or medication prescribed for experimental indications.
- Syringes and/or needles except those dispensed for use with Insulin. While not covered under this Prescription Drug benefit, under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, these items are covered under the sections describing benefits for “Home Health Care”, “Infusion Therapy”, “Treatment for Diabetes” and/or “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, durable medical equipment, devices, appliances, and supplies are specified as covered under the section describing benefits for “Medical Supplies and Equipment”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, lancets and test strips for use in the monitoring of diabetes are specified as covered under the section describing benefits for “Treatment for Diabetes”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen. While not covered under this Prescription Drug benefit, if you need those items, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, these services are covered under the sections describing benefits for “Professional Services and Supplies”, “Preventive Care”, “Medical Supplies and Equipment”, “Infusion Therapy” and “Well Baby and Well Child Care”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.

- Professional charges in connection with administering, injecting or dispensing of Drugs. Infusion medications. While not covered under this Prescription Drug benefit, under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, these services are specified as covered under the sections describing benefits for “Professional Services and Supplies” and for “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medication dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and doctor’s offices. While not covered under this Prescription Drug benefit, if you need such Drugs in an outpatient setting, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, these drugs are specified as covered under the sections describing benefits for “Professional Services and Supplies”, “Hospital Services” and “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs used for cosmetic purposes (e.g., Retin-A for wrinkles).
- Drugs used for the primary purpose of treating infertility.
- Drugs used for weight loss except for the Medically Necessary treatment of morbid obesity.
- Drugs obtained outside of the United States unless related to a Medical Emergency.
- Allergy desensitization products, allergy serum. While not covered under this Prescription Drug benefit, if you need such Drugs, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, Drugs (which reference would include allergy desensitization products, allergy serum) are covered under the sections describing benefits for “Professional Services and Supplies”, “Hospital Services” and “Skilled Nursing Facilities”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- All Infusion Therapy except Self-administered injectables and aerosols, is excluded under this Prescription Drug benefit. While not covered under this Prescription Drug benefit, if you need Infusion Therapy, you will want to know the following:
 - Under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, Infusion Therapy is specified as covered under the sections describing benefits for “Professional Services and Supplies” and for “Infusion Therapy”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to Anthem for review. Drugs and medications for treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per 30-day period. **Not covered under Mail Order Prescription Drug Program.**
- Hepatitis B and varicella zoster (chicken pox) vaccines for Members age 7 through 18 and childhood immunizations. While not covered under this Prescription Drug benefit, under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM, these immunizing agents are specified as covered under the section describing benefits for “Professional Services and Supplies”, subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.

Claims and Customer Service:

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

Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165
or call 1-800-700-2533

For **Mail Order Prescription Drug Program** information, please write to:

Anthem Blue Cross Mail Order Prescription Drug Program
P.O. Box 961025
Fort Worth, TX 76161-9863
or call 1-866-274-6825

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 Agreement. All Covered Services are subject to review by Anthem for medical necessity.

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

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

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

Revoking or modifying an authorization.

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

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

Preservice Review is required for, but not limited to:

- All inpatient Hospital admissions (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy).
- Facility Based Treatment for Severe Mental Illness 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.
- Center 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) scan
 - Computerized Tomography (CT) scan
 - Positron Emission Tomography (PET) scan
 - Nuclear Cardiology (NC) scan

Note: Other specific procedures, wherever performed, as specified by Anthem. For a list of current procedures, please contact Anthem toll free at 1-800-274-7767 or visit our website at www.anthem.com/ca.

Admission Review. Anthem will determine at the time of admission if the service is Medically Necessary in the event Preservice Review is not conducted (except for inpatient Hospital stays related to the delivery of a Child or 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 an admission to a Hospital, Facility Based Treatment for Mental or Nervous Disorders or Substance Abuse or any surgery at a Hospital or an Ambulatory Surgical Center was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

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

ALTERNATIVE BENEFITS

In order for a Member to obtain medically appropriate care in a more economical and cost effective way when extensive long-term treatment is required, Anthem may recommend an alternative plan of treatment which includes services not covered under this Agreement.

Anthem makes treatment suggestions only; any decision regarding treatment belongs to the Member and the Member's Physician. When alternative treatments are to be provided, both the Member or Member's guardian and the Member's Physician must agree, in writing, with the terms and conditions of Anthem's recommended substitution of benefits.

Benefits are provided for such alternative treatment plan only on a case-by-case basis. Anthem has absolute discretion in deciding whether or not to offer to substitute benefits for any Member, 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 Member. Also, it does not prevent Anthem from strictly applying the express benefits, limitations and exclusions of the Agreement at any other time or for any other Member.

GENERAL PROVISIONS

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

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

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

- The Member 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 Member 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 Member 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 have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.
 - Please contact customer service toll free at 1-800-333-0912 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

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 Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. 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 "GRIEVANCE PROCEDURES."

In accordance with California law, Members will not be required to pay any Participating Provider for amounts owed to that provider by Anthem even in the unlikely event that Anthem fails to pay the Provider. This does not include Copayment/Coinsurance, Deductibles and services or supplies that are not a benefit of this Agreement. Members are liable, however, to pay Non-Participating Providers for any amounts not paid to them by Anthem.

Form or Content of Agreement: NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS, CONDITIONS OR BENEFITS OF THIS AGREEMENT. Any changes can only be made through an endorsement signed and authorized by one of our officers.

Governing Law: Anthem is subject to the requirements of the Knox-Keene Health Care Service Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and at Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulation, and any provision required to be stated herein by either of the above shall bind Anthem whether or not provided in this Agreement. This Agreement shall be construed and enforced in accordance with the laws of the State of California.

Notice: We will meet any notice requirements by mailing the Notice to you at the address listed on our records. You will meet any notice requirements by mailing the notice to: Anthem Blue Cross 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 Members 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. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912. 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 (“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 Subscriber 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 Subscriber 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: Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care facilities may be paid either a fixed fee or on a discounted fee for service basis. We pay the benefits of this Agreement directly to Contracting Hospitals, Participating Hospitals, Participating Physicians, medical transportation providers, certified nurse midwives and registered nurse practitioners and other Participating Providers, whether or not you have authorized an assignment of benefits. 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 Family members receives services from a Non-Participating Provider or Non-Contracting Hospital, payment may be made directly to the Subscriber 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. We will pay non-contracting Hospitals and other providers of service directly when emergency services and care are provided to you or one of your family members. We will continue such direct payment until the emergency care results in stabilization.

Anthem shall provide written notice to you within a reasonable period of time of any Participating Provider’s termination or breach of, or inability to perform under, any provider contract, if Anthem determines that you or your Family Members may be materially and adversely affected thereby.

Prior Anthem Coverage: If the Member was covered by a prior Individual Coverage Anthem Agreement which is replaced by this Agreement, benefits used under the prior Agreement will be charged against the benefits payable under this Agreement.

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

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Contact our customer service department at 1-800-333-0912 for a copy.

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

Relationship of Parties: We are not responsible for any claim for damages or injuries suffered by the Member while receiving care in any Hospital or Skilled Nursing Facility.

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

Submission of Claims: Either the Subscriber 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 15 months from the date the services or supplies are received. Anthem will not be liable for benefits if it does not receive completed claim forms within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Termination of Providers: Anthem will provide you with a notice of termination of a general acute Hospital from which you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To locate another Hospital in your area, call our customer service department at 1-800-333-0912.

Terms of Coverage:

- In order for you to be entitled to benefits under this Agreement your coverage under this Agreement must be in effect on the date you receive the service or supply, except as specifically provided under in the part entitled DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT. Under this Agreement, an expense is incurred on the date the Subscriber or Family Member receives a service or supply for which the charge is made.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the part entitled DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT.
- The benefits to which you may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date you receive the service or supply.

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

PUBLIC POLICY PARTICIPATION

We have established a public policy committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity and convenience of the people we cover. The committee consists of Members covered by our health plan, Participating Providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

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

HOWEVER, THE AMOUNT OF BENEFITS PAYABLE UNDER THIS AGREEMENT WILL BE DIFFERENT FOR NON-PARTICIPATING PROVIDERS THAN FOR PARTICIPATING PROVIDERS. PLEASE READ THE BENEFIT SECTIONS CAREFULLY TO DETERMINE THOSE DIFFERENCES.

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.

GRIEVANCE PROCEDURES

If you have a question about your eligibility, your benefits under this Agreement, or concerning a claim, please call customer service at 1-800-333-0912, or you may write to us. Please address your correspondence to Anthem Blue Cross, P.O. Box 9051, Oxnard, CA 93031-9051, marked to the attention of the Customer Service Department. Our customer service staff will answer your questions or assist you in resolving your issue.

If you are dissatisfied and wish to file a grievance, you may request a copy of the grievance form to complete and return to us. You may also ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance form online in the "Members" section at www.anthem.com/ca. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. You must include all pertinent information from your identification card and the details and circumstances of your concern or problem. Upon receipt of your grievance, your issue will become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing. After we have reviewed your grievance, we will send you a written statement on its resolution or pending status. If your case involves an imminent and serious threat to your health including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, you have the right to request an expedited review of an appeal. Expedited appeals **must be resolved** within three (3) days.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least thirty (30) days, you may submit your grievance to the Department of Managed Health Care. For review prior to binding arbitration see the section Department of Managed Health Care. If your case involves an imminent and serious threat to your health, as described above, you are not required to complete our grievance process, but may immediately submit your grievance to the Department of Managed Health Care for review.

You may at any time pursue your ultimate remedy, which is Binding Arbitration. See the part entitled BINDING ARBITRATION.

INDEPENDENT MEDICAL REVIEW BASED UPON THE DENIAL OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

If a Member has had coverage denied because proposed treatment is determined by us to be investigational or experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described under "Independent Medical Review of Grievances Involving a Disputed Health Care Service."

To qualify for independent medical review, all of the following conditions must be satisfied:

- The Member has 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 Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If independent medical review is requested by the Member or by a qualified Non-Participating Physician, as described above, the requester must supply two items of acceptable medical and scientific evidence (as defined below).
- Within three (3) business days of our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review, we will provide the independent medical review organization designated by the Department with a copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member's Physician. Any subsequent information received will be forwarded to the independent medical review 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 immediately be forwarded to the independent medical review organization. The independent medical review 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.

"Acceptable medical and scientific evidence" 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;
- The American Hospital Formulary Service's-Drug Information and the American Dental Association Accepted Dental Therapeutics;
- 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.
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances involving a Disputed Health Care Service

You may request an Independent Medical Review (“IMR”) of disputed health care services from the Department of Managed Health Care (DMHC) if you believe that we have improperly denied, modified, or delayed health care services. A “disputed health care service” is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part, because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. 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.

Eligibility

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

1. a. Your provider has recommended a health care service as Medically Necessary, or
b. You have received urgent care or emergency services that a provider determined was Medically Necessary, or
c. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. 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
3. 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 DMHC’s attention. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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 Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC 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.

For more information regarding the IMR process, or to request an application form, please call our customer service department toll free at 1-800-333-0912.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-333-0912** and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department’s Internet Web site **<http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions on-line.

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, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the 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. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.*

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. 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, or by order of the court, if the Member and Anthem Blue Cross 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
P.O. Box 9086
Oxnard, California 93031-9086.

COMPLAINTS

If you have a complaint about services from Anthem or your health care provider, contact Anthem at 1-800-333-0912 or address indicated on your Identification Card.

DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT

Enrollment will be cancelled as of the last date for which payment has been received, subject to compliance with notice requirements.

- A. The effective date of your coverage is printed on your Anthem identification card.
- B. The duration of your coverage under this Agreement depends on how your subscription charges are billed, and is equal to the length of time between billing cycles. For example, if we bill subscription charges on a bi-monthly basis, your coverage is for a two-month duration. If we bill subscription charges 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 subscription charges on a monthly basis, your coverage is for a one-month duration. The duration of the Agreement is determined by how you pay your subscription charges (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 Agreement expires at the end of each billing cycle, it will, upon timely payment of the billed subscription charges, automatically renew under the same terms and conditions unless (1) Anthem has terminated, canceled, or declined to renew the Agreement pursuant to Paragraph D. below; or (2) Anthem has modified the Agreement pursuant to Paragraph F. below.
- D. Anthem may, at any time, terminate, cancel or decline to renew this Agreement in the event of any of the following:

1. Your failure to pay subscription charges as required herein.

If you fail to pay subscription charges as they become due, Anthem may terminate this Agreement only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The termination will be effective as of 12:00 midnight on the fifteenth (15th) day after the date on which the Notice of Cancellation is sent. The Notice of Cancellation shall state that this Agreement shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem issues the Notice of Cancellation.

The Notice of Cancellation also shall inform you that, if this Agreement is terminated for nonpayment and you wish to apply for reinstatement, you will be required to submit a new application for coverage and will be required to submit any dues that are owed, in addition to a \$50 reinstatement fee, and you will be subject to medical underwriting.

2. When the Member has committed an act, practice or omission that constitutes fraud or an intentional misrepresentation of a material fact on the application, in the submission of claims or the use of services or facilities of Anthem, or your knowingly permitting such fraud, deception or an intentional misrepresentation of material fact by another. This Agreement may also be terminated if you knowingly participated in or permitted any act, practice or omission that constitutes fraud, deception or an intentional misrepresentation of material fact by any provider, vendor or any other person associated with this Agreement. Termination is effective on the date of mailing the written notice. Please see the part entitled ELIGIBILITY for information on continuing coverage for eligible Insureds on rescinded Policies. We will give you at least (thirty) 30 days written notice prior to rescission of this Agreement.
3. On the first of the month following our receipt of your written notice to cancel.
4. Your coverage may end if you become ineligible as stated in the section, When the Member Becomes Ineligible, in the part entitled ELIGIBILITY. Your coverage will end on the date specified in the notice, but not earlier than thirty-one (31) days after the date of the notice.
5. If we decide to leave the individual market or cease to offer individual PPO or HMO coverage in the state or in the HMO service area and if we have given the Director of the Department of Managed Health Care at least 180 days prior written notice, we may not renew this Agreement. Any non-

renewal shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 180 days following the date of the notice. We will provide You the option to apply for individual conversion coverage as described under the part entitled CONVERSION PRIVILEGE.

6. If we decide to discontinue this plan and if we have given the Director of the Department of Managed Health Care at least 90 days prior written notice, we may terminate this Agreement. We will give you written notice of any such termination, and any such termination shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 90 days following the date of the notice. We would make available continued coverage under any of the other plans we offer to individuals, without regard to your health status.
7. If you are in the Hospital or Skilled Nursing Facility on the date we cancel your coverage on written notice as described in paragraph 6, benefits will continue until whichever of the following occurs first:
 - a. The date of discharge from the Hospital or Skilled Nursing Facility, or
 - b. Care or treatment is no longer Medically Necessary, or
 - c. The maximum benefits have been furnished.

If this Agreement is terminated for any cause any subscription charges received by Anthem for periods occurring after the effective date of that termination, less any amounts due to Anthem, will be refunded to you, and Anthem shall have no further liability or responsibility with regard to any Members under this Agreement. If the termination is for any reason other than you or a Family Member's fraud or deception in the use of services or facilities of Anthem or knowingly permitting such fraud or deception by another, Anthem will make this refund to you within thirty (30) days.

Your coverage may not be terminated because of your health status or requirements for health care services. If you believe that your coverage has been terminated for either of these reasons, you may request a review of the matter by the Director of Department of Managed Health Care.

- E. Intentional incomplete or false material information on Your application may result in rescission of this Agreement. This means Anthem will cancel membership back to the original Effective Date of the Agreement, as if it never existed. If the Agreement is revoked, You will be sent a written notice
- F. In addition to the right to terminate, cancel or decline to renew the Agreement set forth in Paragraph D., Anthem has the right upon renewal, or at any time during the duration of your Agreement, to modify or otherwise change benefits, terms and conditions of your Agreement, **including subscription charges**, provided that Anthem gives you thirty (30) days' prior written notice from the postage paid mailing date of such modifications or changes. Such modifications or changes may alter or otherwise change the benefits, terms and conditions of this Agreement, including without limitation, subscription charges, covered benefits, Deductibles, copayments or coinsurance. Anthem can modify or change the terms and conditions of your Agreement 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.
- G. In addition to the thirty (30) days' written notice provision set forth above, Anthem's right to modify this Agreement under Paragraph F. is subject to the following conditions:
 1. Anthem will not modify this Agreement under Paragraph F. on an individual basis, but only for all Members in the same class and covered under the same plan as you.
 2. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph B., above) on or after the 30th day following the date of the above notice.

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

You should address any written notice to us at: Anthem Blue Cross, P. O. Box 9051, Oxnard, California 93031-9051.

NON-DUPLICATION OF ANTHEM BENEFITS

If, while covered under this Individual Agreement, you are also covered by another Anthem Blue Cross Individual Agreement:

1. You will be entitled only to the benefits of the Agreement with the greater benefits, and
2. We will refund any subscription charges received under the Agreement with the lesser benefits, covering the time period both Agreements were in effect. However, any claims payments made by us under the Agreement with the lesser benefits will be deducted from any such refund of subscription charges.

THIRD PARTY LIABILITY

Under some circumstances, a third party may be liable or legally responsible by reason of negligence, an intentional act, or the breach of a legal obligation of such third party for an injury, disease, or other condition for which a Member receives Covered Services. In that event, any benefits we pay under this Agreement for such Covered Services will be subject to the following:

- We will automatically have a lien upon any amount you receive from the third party or the third party's insurer or guarantor by judgment, award, settlement or otherwise. Our lien will be in the amount of the benefits we pay under this Agreement for treatment of the illness, disease, injury or condition for which the third party is liable. Our lien will not exceed the amount we actually paid for those services, if we paid the provider other than on a capitated basis, and, if we paid the provider on a capitated basis, our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered. In addition, if you engaged an attorney to gain your recovery from the third party, one-third of the monies due you under any final judgment, compromise, or settlement agreement and, if you did not engage an attorney, our lien shall not be for a sum in excess of one half of the monies due you under any final judgment, compromise or settlement agreement. Where a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, our lien shall be reduced by the same comparative fault percentage by which your recovery was reduced. Our lien is subject to a pro rata reduction commensurate with your reasonable attorney's fees and costs in accordance with the common fund doctrine.
- You agree to advise us in writing of your claim against a third party within sixty (60) days of making such claim, and that you will take such action, furnish such information and assistance, and execute such papers as we may require to facilitate enforcement of our lien rights. You agree not to take any action that may prejudice our rights or interests under this Agreement. You agree also that failing to give us such notice, or failing to cooperate with us, or taking action that prejudices our rights will be a material breach of this Agreement. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.
- We will be entitled to collect on our lien even if the amount recovered by or for the Member (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

CONVERSION PRIVILEGE

- Members who are 65 years of age or older may apply for an Anthem Plan which supplements Medicare benefits.
- Family Members who lose eligibility for coverage under this Agreement may apply for their own coverage.
- If your dependent does not meet the qualifications to remain as a dependent on your plan, Anthem will automatically enroll your dependent, if a resident of California, on the same plan, under his/her own identification number.
- The written application for Conversion coverage must be submitted to us within thirty-one (31) days of the loss of eligibility. We will not need proof of good health.
- If you move outside of California, you will not be eligible for a Conversion Plan or Medicare Supplement Plan with the Blue Cross or Blue Shield Plan serving your new address. Options to continue individual coverage include the following:
 - Transfer your coverage to the Blue Cross or Blue Shield Plan serving your new address. The type of coverage offered will be at the discretion of the new Blue Cross or Blue Shield Plan.
 - Submit an application for a UNICARE Life & Health Insurance Company policy in a state in which UNICARE offers individual policies and coverage shall be subject to UNICARE's acceptance or rejection according to its underwriting standards.
- SERVICES, BENEFITS AND SUBSCRIPTION CHARGES UNDER A CONVERSION AGREEMENT OR MEDICARE SUPPLEMENT MAY NOT BE THE SAME AS THOSE PROVIDED UNDER THIS AGREEMENT.

DEFINITIONS

Here are the meanings of some of the words or terms used in this booklet. While reading this booklet, if you see a term that is capitalized you should refer to these definitions.

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

Anthem Blue Cross (“Anthem”) is a health care service plan. We are regulated by the Department of Managed Health Care.

Authorized Referral occurs when a Member, 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:

1. There is no Participating Physician who practices in the appropriate specialty or there is no Participating Hospital or Participating Ambulatory Surgical Center which provides the required services or has the necessary facilities within a 30-mile radius of the principal residential address as reflected on our files or within the county in which the principal residence is located whichever is less, and
2. The Member is referred to the Non-Participating Provider by a Participating Physician, and
3. The referral has been authorized by Anthem before services are rendered.

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

Coinsurance is the percentage amount due and payable by the Member to the provider of care after your Deductible is satisfied.

Contracting Hospital is a Hospital that has a contract with us to provide care to our Members. However, this does not necessarily make it a Participating Hospital. A list of Contracting Hospitals will be sent to you on request.

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

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 that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: to improve function, or to 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 Agreement and for which you are entitled to receive benefits.

Creditable coverage means:

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 the 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)).

Customary and Reasonable Charge is the average price that a majority of doctors charged for a particular procedure based on where the procedure is performed and the complexity and severity of the treatment.

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

Deductible means the amount of charges you must pay for any Covered Services and Prescription Drugs before any benefits are available to you under this Agreement. Your Yearly Deductible is stated in the part entitled BENEFIT COPAYMENT/COINSURANCE LIST. Your Brand Name Prescription Drug Deductible is stated in the part entitled YOUR PRESCRIPTION DRUG BENEFITS.

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 Member after the initial diagnosis of diabetes in the care and management of that condition, including 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 Member's symptoms or condition that requires changes in the qualified Member's self-management regime; and periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes. Diabetes Outpatient Self-Management Training must be provided by a health care practitioner or provider who is licensed, registered or certified in California to provide appropriate health care services.

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

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.

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

For the purpose of Severe Mental Illness and Serious Emotional Disturbances of a Child only, the term "Hospital" includes an acute psychiatric facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24 hour acute inpatient care for persons with psychiatric disorders. For the purposes of this plan, 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:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations, and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director, and
5. Actually providing an acute level of care.

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 Agreement, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

Medical Emergency, as determined by us means a Psychiatric Emergency Medical Condition or a sudden onset of a medical 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:

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

Medical Emergency includes being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

Within or outside of California, Medical Emergency includes urgently needed services to prevent serious deterioration of the health of a Member or the Member's fetus resulting from unforeseen illness, injury or

complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Plan's service area.

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

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

Member shall mean both the Subscriber and all other Family Members who are enrolled or automatically enrolled for coverage under this Agreement.

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 (e.g. 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, antisocial 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 Agreement. **However, medical services provided to treat medical conditions that are caused by behavior of the Member that may be associated with these mental conditions (e.g., self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to these limitations.**

Negotiated Fee Rate is the amount of payment that Anthem has negotiated with the Participating Provider under a Prudent Buyer Participating Agreement.

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

Non-Contracting Hospital is a Hospital that does not have a standard contract nor a Prudent Buyer Participating Hospital Agreement with Anthem Blue Cross. No benefits are available for care furnished in Non-Contracting Hospitals in California except for Medical Emergencies as outlined in the Special Circumstances section of the part entitled BENEFIT COPAYMENT/COINSURANCE LIST.

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

Only a portion of the amount which a Non-Participating Provider charges for services will be paid by Anthem. The Member will be responsible for any billed charges over the amount allowed under this Agreement. See the part entitled BENEFIT COPAYMENT/COINSURANCE LIST to determine your payment responsibility when using Non-Participating Providers.

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 that 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 Members for Covered Services under this Agreement. 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 directory of Participating Providers is available upon request through our Customer Service Representatives.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice where the care is provided, or
- One of the following providers, but only when the provider is licensed to practice where the health care service is provided, is rendering a Covered Service within the scope of that license, is providing a Covered Service for which benefits are specified in this Agreement, and when benefits would be payable if the services were provided by a Physician as defined above:
 - A dentist (D.D.S.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M. or D.S.C.)
 - A psychologist
 - A clinical psychologist

- A chiropractor (D.C.)
- A certified registered nurse anesthetist
- An acupuncturist
- 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*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory therapist*
- A psychiatric mental health nurse
- A Physician assistant*
- A certified nurse midwife
- A registered nurse practitioner

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

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 practitioner during the six (6) months immediately preceding the Member's effective date of coverage. No pre-existing waiting period for any conditions for any covered Insured under the age of 19.

Preferred Participating Hospital is a Hospital that has entered into a Preferred Participating Agreement with Anthem. A list of these Preferred Participating Hospitals is available upon request from our Customer Service Representatives.

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.

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:

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

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

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

- Pervasive developmental disorders, including autistic disorder, Rett's syndrome, childhood disintegrative disorder, Asperger's disorder, and other pervasive developmental disorders not otherwise specified including atypical autism.

Note: Coverage for Severe Mental Illness and Serious Emotional Disturbances of a Child will be provided in accordance with the Plan provisions for any other medical diagnosis and not in accordance with the Plan provisions for Mental or Nervous Disorders.

Skilled Nursing Facility is a facility that provides continuous nursing services. It must be licensed according to state and local laws and be recognized as a Skilled Nursing Facility under Medicare. For purposes of Severe Mental Illness and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a residential treatment center which is an inpatient treatment facility where the Member 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.

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.

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

SUBSCRIPTION CHARGES

The subscription charges are payable in advance and due the first of the month.

There are different billing options available:

Paper Bill

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

Checking Account Deduction Program/Credit Card

- Monthly (1 month)

Note: An administrative fee of \$2.00 may be added for a paper bill or credit card.

IMPORTANT: If you are enrolled in the Anthem 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 subscription charge due date, we will not be able to make the requested change in time to coincide with your subscription charge due date. For the above listed changes a new authorization form is required. We will send you the necessary form upon request by calling us at 1-800-333-0912.

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.

Subscription Charges are the monthly charges the member must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required subscription charges based on the Subscriber's age and the specific regional area in which the Subscriber resides. If the Subscriber changes residence, he or she may be subject to a change in subscription charges. Such change in subscription charges 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 Subscriber for the difference in subscription charges from the date the address changed. Anthem will recalculate your subscription charge based upon the age of the Subscriber, or the spouse whichever is younger and your subscription charge will be adjusted to the new rate prior to any other subscription charge change. Anthem will send out written notification 30 days in advance of such change.

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 subscription charge 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.

Please be sure to read the part entitled DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY OR RESCIND YOUR AGREEMENT for additional terms and conditions.