



**ENDORSEMENT TO THE INDIVIDUAL
SMARTSENSE PLUS CONTRACT**

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

Effective December 1, 2010, the following revisions have been made to your Individual Policy issued to you by Anthem Blue Cross Life and Health Insurance Company as follows:

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

1. The contract code for the Policy is changed to 01KJ.
2. This Policy contains no lifetime dollar limits or annual dollar limits on essential health benefits.
3. Coverage cannot be rescinded unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact. After 24 months following issuance, the policy may not be rescinded for any reason.

If coverage of an individual is rescinded, written notice will be sent explaining the basis for the decision and the individual's appeal rights.

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

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

5. No pre-existing condition waiting period, limitation or exclusion will be applied to any Insured under the age of 19.

6. Coverage for preventive benefits, as defined in the Act, does not require payment of any Deductible, Copayment, or Coinsurance if obtained from a Participating Provider. If obtained from a Non-Participating Provider, the member will pay 50% of the Negotiated Fee Rate, plus all charges in excess of the Negotiated Fee Rate. The following are covered preventive benefits:
 - (a) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
 - (b) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
 - (c) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
 - (d) with respect to women, such additional preventive care and screenings not described in paragraph (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
 - (e) the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued on or around November 2009.
7. Except where an Insured's life or health would be seriously jeopardized, you must first exhaust our internal grievance process before we will grant your request for an external review. In no event shall your rights to an external review be any more restrictive than that set forth in the Uniform External Review Model Act established by the National Association of Insurance Commissioners (NAIC), by the Secretary of Health and Human Services (HHS) or within your state external review act, as applicable under state and federal law. There is no fee for an external review. If you have a question about our internal grievance process, filing a grievance, or the external review process, please call customer service at 1-800-333-0912, or you may write to us. Please address your correspondence to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051, Oxnard, CA 93031-9051, marked to the attention of the Customer Service Department.
8. Insureds covered under this Policy are not required to designate a primary care physician.
9. Emergency services from Non-Participating Providers will be covered at the same benefit and cost sharing level as services provided by Participating Providers. Prior authorization for emergency services is not required.
10. The following definitions have been added or changed:

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

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

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

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

Stabilize means, with respect to an emergency medical condition:

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

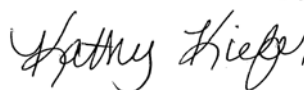
This Endorsement, December 1, 2010, is part of your Anthem Blue Cross Life and Health Individual Policy. Please keep all of your documents together. This Endorsement terminates concurrently with the Policy to which it is attached.

This Endorsement is subject to all the definitions, limitations, exclusions and conditions of the Policy except as stated herein. This Endorsement applies notwithstanding any other provisions of the Policy or Certificate and to the extent there is a conflict between the Policy and this Endorsement, the terms of this Endorsement shall apply. Authorized officers of Anthem Blue Cross Life and Health Insurance Company have approved this endorsement as of the effective date.

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY



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



Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company



Individual SmartSense Plus with Upgrade Rx \$6,000
01KJ

Dear Anthem Blue Cross Life and Health Insurance Company Insured,

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

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

If you have any questions regarding your eligibility, claims status or your benefits under this Policy, please feel free to contact us at 1-800-333-0912 or write to us at Anthem Blue Cross Life and Health P.O. Box 9051 Oxnard, California 93031-9051.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company

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

HOW TO CONTACT US

Anthem Blue Cross Life and Health Insurance Company's 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 Life and Health Insurance Company P.O. Box 9051 Oxnard, CA 93031-9051
Medical Claims and Benefits	Claims	(800) 333-0912	Anthem Blue Cross Life and Health Insurance Company P.O. Box 60007 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 Life and Health Prescription Drug Program P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (Mail Service)	Pharmacy Benefits Manager	(866) 274-6825	Anthem Blue Cross Life and Health Mail Service Prescription Drug Program P.O. Box 746000 Mason, OH 45274 www.anthem.com/ca
Pharmacy (SpecialtyRx)	Pharmacy Benefits Manager	(800) 870-6419	PrecisionRx 2825 W. Perimeter Suite 116 Indianapolis, IN 46241 www.anthem.com/ca

TABLE OF CONTENTS

MEMBER RIGHTS AND RESPONSIBILITIES.....	1
INTRODUCTION.....	2
ELIGIBILITY	5
WHEN AN INSURED BECOMES INELIGIBLE.....	7
MAXIMUM COMPREHENSIVE BENEFITS	8
BENEFIT COPAYMENT/COINSURANCE LIST	11
COMPREHENSIVE BENEFITS: WHAT IS COVERED.....	21
EXCLUSIONS AND LIMITATIONS	34
YOUR PRESCRIPTION DRUG BENEFITS	38
UTILIZATION MANAGEMENT AND PRESERVICE REVIEW.....	49
ALTERNATIVE BENEFITS	50
GENERAL PROVISIONS	51
INDEPENDENT MEDICAL REVIEW OF GRIEVANCES	55
BINDING ARBITRATION	57
DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY	59
NON-DUPLICATION OF ANTHEM BENEFITS	60
DEFINITIONS	61
MONTHLY PREMIUMS.....	68

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 Subscriber Agreement and not by this Member Rights and Responsibilities statement.

**01KJ
ANTHEM BLUE CROSS LIFE AND HEALTH
SmartSense Plus Upgrade Rx \$6,000**

A Prudent Buyer Plan

Issued By
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

INTRODUCTION

This policy will not begin to pay for your health care expenses until after your health care bills exceed the deductible amount. You will have to pay for all of your health care bills until these bills exceed your deductible amount.

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

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

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

This is a Preferred Provider Organization (PPO) Plan. We provide access to a network of Hospitals and Physicians who contract with Anthem Blue Cross Life and Health Insurance Company (Anthem) to facilitate services to our Insureds and who provide services at pre-negotiated discounted fees. Covered Expenses for Participating Providers are based on the Negotiated Fee Rate. Participating Providers have a Prudent Buyer Participating Provider Agreement in effect with us and have agreed to accept the Negotiated Fee Rate as payment in full. Non-Participating Providers do not have a Prudent Buyer Participating Provider Agreement with Anthem. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers. Please read the benefit sections carefully to determine those differences. For a directory of Participating Providers or additional information, you may contact our customer service department at 1-800-333-0912.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Policy and that you or your Dependents 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 Policy, “we,” “us” and “our” mean Anthem Blue Cross Life and Health Insurance Company (Anthem). You are the eligible Policyholder whose individual enrollment application has been accepted by us. “You” and “your” also mean any eligible Dependents who were listed on your individual enrollment application and accepted by us for coverage under this Policy. When we use the word “Insured” in this Policy, we mean you and any eligible Dependents who are covered under this Policy.

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

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

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

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

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

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY AND ATTENDING PHYSICIAN

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

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

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

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

This is not an annual Policy. The duration of your coverage depends on the method of payment you chose under Paragraph B. under the part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, and is not affected by any provisions defining your Deductible or other cost sharing obligations. Your Policy expires at the end of each billing cycle but will automatically renew upon timely payment of your next premium charge, subject to our right to terminate, cancel or non-renew as described in the part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, Paragraph D. Also, premiums, benefits, terms and conditions may be modified at any time during the Year following sixty (60) days written notice pursuant to the part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY**, Paragraph E. Please read the part entitled **DURATION AND TERMINATION OF YOUR POLICY AND OUR RIGHT TO MODIFY YOUR POLICY** carefully and in its entirety to make sure you fully understand the duration of your coverage and the conditions under which we can change, terminate, cancel or decline to renew your Policy.

You hereby expressly acknowledge that you understand this policy 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 policy 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 You for any of Anthem's obligations to You created under this policy. 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.

ELIGIBILITY

Who is Eligible for Coverage

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

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

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

Overage Dependents and Dependents Enrolled as a Full-time Student

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

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

Newborns and Adopted Children

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

Transferring to Another Individual Plan

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

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

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

Eligibility following Rescission

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

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

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

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

If an Insured was subject to a Pre-existing condition exclusion on a rescinded Policy and continues coverage after the rescission of an Individual Policy, the Insured may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded Policy. This means that we will credit any time that the eligible Insured was covered under the rescinded Policy. The time period in the new Policy for the pre-existing condition exclusion period will not be longer than the one in the Policy that was rescinded.

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

WHEN AN INSURED BECOMES INELIGIBLE

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

- The Policyholder does not pay the premiums when due, subject to the grace period.
- The spouse is no longer married to the Policyholder.
- The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.
- The Dependent fails to meet the eligibility rules listed in the part entitled ELIGIBILITY.
- An Insured moves to and lives in a place outside of California.
- The Insured becomes enrolled under any other Anthem non-group Policy.

Notice of Change in Eligibility

You must notify us of all changes affecting any Insured's eligibility under this Policy except for the first and last bullets listed above under, '**An Insured becomes ineligible for coverage.**' You should address any written notice to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051 Oxnard, California 93031-9051.

Options in the Event of Changed Circumstances

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

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

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

The written application must be submitted to us within thirty-one (31) days of the loss of eligibility. We will not need proof of good health. You should address any written notice to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9051 Oxnard, California 93031-9051.

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

MAXIMUM COMPREHENSIVE BENEFITS

This policy will not begin to pay for your health care expenses until after your health care bills exceed the deductible amount. You will have to pay for all of your health care bills until these bills exceed your deductible amount.

If within the same calendar Year, an Insured replaces any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the Participating Provider or Non-Participating Provider Deductibles, Participating Provider or Non-Participating Provider Yearly Copayment/Coinsurance Maximums or any benefit maximums of that prior Policy, will be applied toward the Participating Provider or Non-Participating Provider Deductibles, Participating Provider or Non-Participating Provider Yearly Copayment/Coinsurance Maximums or any benefit maximums of this Policy.

DEDUCTIBLE

Deductible is the amount of charges you must pay for any Covered Services before any benefits are available to you under this Policy. Amounts for Participating Providers and Non-Participating Providers are applied separately each Year as indicated below.

Participating Provider Deductible

Each Year, You must satisfy your Participating Provider Deductible before we will pay for medical benefits from Participating providers. Your Participating Provider Deductible amount is determined by the number of Insureds enrolled in this Policy, as follows:

- **Individual Deductible: \$6,000** per Year for each Insured. Once you have satisfied your Participating Provider Deductible, no further Participating Provider Deductible will be required for the remainder of that Year.
- **Family Deductible Maximum: \$12,000** per Year for a Family Contract. Once the total of allowable charges applying to the individual Participating Provider Deductible for two (2) or more Insureds equal the Participating Provider Family Deductible Maximum no further Participating Provider Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family amount.

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.

Once the Participating Provider Deductible is met, charges for Covered Services from a Participating Provider apply only to the Participating Provider Yearly Copayment/Coinsurance Maximum.

Non-Participating Provider Deductible

Each Year, You must satisfy your Non-Participating Participating Provider Deductible before we will pay for medical benefits from Non-Participating Participating providers. Your Non-Participating Provider Deductible amount is determined by the number of Insureds enrolled in this Policy, as follows:

- **Individual Deductible: \$6,000** per Year for each Insured. Once you have satisfied your Non-Participating Provider Deductible, no further Non-Participating Provider Deductible will be required for the remainder of that Year.
- **Family Deductible Maximum: \$12,000** per Year for a Family Contract. Once the total of the allowable charges applying to the individual Non-Participating Provider Deductibles for two (2) or more Insureds equal the Non-Participating Provider Family Deductible Maximum no further Non-Participating Provider Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family amount.

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

During each Year, each Insured is responsible for all expenses incurred up to the Deductible amounts. These Deductibles are not prorated for a partial Year. Only Covered Expense will apply toward the Deductibles. A claim must be submitted in order for us to record your eligible covered Deductible expense. We will record your Deductibles in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. The automatic enrollment of a Newborn or Adopted Children under the Eligibility section may cause the applicable deductible to automatically change from the Individual Deductible to a Family Deductible.

If you submit a claim for services which have a maximum payment limit and neither of your Deductibles are satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Participating Provider or Non-Participating Provider Deductible, whichever applies.

Once the Non-Participating Provider Deductible is met, charges for Covered Services from a Non-Participating Provider apply only to the Non-Participating Provider Yearly Copayment/Coinsurance Maximum.

COINSURANCE

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

YEARLY COPAYMENT/COINSURANCE MAXIMUMS

Yearly Copayment/Coinsurance Maximum amounts for Participating Providers and Non-Participating Providers are applied separately each Year, as follows:

Participating Provider Yearly Copayment/Coinsurance Maximum

- **Individual Yearly Copayment/Coinsurance Maximum: \$3,500** per Year for each Insured. Once you have satisfied your Participating Provider Yearly Copayment/Coinsurance Maximum, no further Coinsurance will be required for Participating Providers for the remainder of that Year.
- **Family Yearly Copayment/Coinsurance Maximum: \$7,000** per Year for a Family Contract. Once the total of allowable charges applying to the Individual Yearly Copayment/Coinsurance Maximum for two (2) or more Insureds in a Family Contract equal the Family Yearly Copayment/Coinsurance Maximum no further Coinsurance will be required by any family member for Participating Providers for the remainder of that Year. However, no one person can contribute more than their individual Yearly Copayment/Coinsurance Maximum amount to the Family Yearly Copayment/Coinsurance Maximum.

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

Non-Participating Provider Yearly Copayment/Coinsurance Maximum

- **Individual Yearly Copayment/Coinsurance Maximum: \$7,500** per Year for each Insured in a Policyholder only contract: Once you have satisfied your Non-Participating Provider Copayment/Coinsurance Maximum, no further Coinsurance, except as specified in the "Exception" paragraph below, will be required for the remainder of that Year.
- **Family Yearly Copayment/Coinsurance Maximum: \$15,000** per Year for a Family Contract. Once the total of allowable charges applying to the Family Yearly Copayment/Coinsurance Maximum for two (2) or more Insureds in a Family Contract equal the Family Yearly Copayment/Coinsurance Maximum no further Coinsurance, except as specified in the "Exception" paragraph below, will be required by any family member for Non-Participating Providers for the remainder of that Year. However, no one person can contribute more than their individual Yearly Copayment/Coinsurance Maximum amount to the Family Yearly Copayment/Coinsurance Maximum.

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

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

- **For Non-Participating Providers and/or Non-Contracting Providers:**
 - Services listed under the benefit entitled Mental or Nervous Disorders and Substance Abuse (other than Severe Mental Illnesses and Serious Emotional Disturbances of a Child).
 - Charges over what Anthem allows as Covered Expense.
- **For Non-Contracting Hospitals:**
 - Charges over what Anthem allows as Covered Expense for Medical Emergencies within California.

You will always have to continue to pay any charges over what we allow as Covered Expense for all services rendered by Non-Participating Providers, even after your Non-Participating Provider Yearly Copayment/Coinsurance Maximum and Deductible have been reached.

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

YEARLY OUT OF POCKET MAXIMUM FOR COVERED SERVICES AND COVERED CHARGES

PARTICIPATING PROVIDER YEARLY OUT OF POCKET MAXIMUM FOR COVERED SERVICES AND COVERED CHARGES

The Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges is the sum of the Participating Provider Deductible and Participating Provider Yearly Copayment/Coinsurance Maximum. Since your policy has a Participating Provider Deductible of **\$6,000** and a Participating Provider Yearly Copayment/Coinsurance Maximum of **\$3,500**, then the Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges is **\$9,500**. After you have satisfied the Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges, Anthem will provide benefits at 100% of the Negotiated Fee Rate for Participating Providers.

Non-participating provider YEARLY OUT OF POCKET MAXIMUM FOR COVERED SERVICES AND COVERED CHARGES

The Non-Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges is the sum of the Non-Participating Provider Deductible and Non-Participating Provider Yearly Copayment/Coinsurance Maximum. Since your policy has a Non-Participating Provider Deductible of **\$6,000** and a Non-Participating Provider Yearly Copayment/Coinsurance Maximum of **\$7,500**, then the Non-Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges is **\$13,500**. After you have satisfied the Non-Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges, Anthem will provide benefits at 100% of the Covered Expense for Non-Participating Providers. You will always have to continue to pay any charges over what we allow as Covered Expense for all services rendered by Non-Participating Providers, even after your Non-Participating Provider Yearly Out of Pocket Maximum for Covered Services and Covered Charges has been reached.

BENEFIT COPAYMENT/COINSURANCE LIST

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

DETERMINATION OF COVERED EXPENSE

- Covered Expense is the expense you incur for Covered Services up to the maximum amount Anthem will allow for a Covered Service or supply. Covered Expense is not necessarily the amount a provider ordinarily bills for a service or supply. When you obtain a Covered Service or supply, Covered Expense is the amount that is used to determine how much Anthem will allow in a claim. It is also used to determine the amount that is applied to your Participating Provider or Non-Participating Provider Deductibles, Participating Provider or Non-Participating Provider Out of Pocket amounts. Covered Expense is incurred on the date you receive the service or supply for which the charge is made. **Please review this part entitled Benefit Copayment/Coinsurance List for any per day, Year or visit limits which may be applied to a particular benefit.**
- In no event will Covered Expenses exceed:
 - Any charge for services of a Participating Hospital, Participating Physician, Participating Skilled Nursing Facility, Participating Hospice, Participating Ambulatory Surgical Center, Participating Home Health Care Provider or Participating Infusion Therapy Provider in excess of the Negotiated Fee Rate.
 - Any charge for services of a Non-Participating Physician in excess of the Negotiated Fee Rate except if Special Circumstances apply in which case Covered Expense will not exceed Customary and Reasonable Charge.*
 - Any charge for services of a Non-Participating Hospital in excess of a Reasonable Charge.*
 - Any charge for services of a Non-Participating Ambulatory Surgical Center, Hospice, Skilled Nursing Facility or Home Health Care Provider in excess of a Customary and Reasonable Charge.*
 - Any charge in excess of \$50 per day for administrative and professional services of a Non-Participating Infusion Therapy Provider; or any charge in excess of the Average Wholesale Price for Drugs provided by a Non-Participating Infusion Therapy Provider. **The combined maximum Covered Expense for a Non-Participating Infusion Therapy Provider will not exceed \$500 per day for all Drugs, professional and administrative services.**
 - Any charge in excess of a Reasonable Charge for all other covered providers, services and supplies for which Anthem does not enter into Prudent Buyer Participating Agreements.

Your personal financial costs when using Non-Participating Providers will be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers. 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 the few Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated in the section entitled, **Special Circumstances**.

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

SECOND OPINIONS

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

INPATIENT HOSPITAL

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

Participating Hospital

30% of the Negotiated Fee Rate.

Non-Participating Hospital

All charges in excess of \$650 per day 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 when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery under the part entitled Comprehensive Benefits: What Is Covered.

OUTPATIENT HOSPITAL and AMBULATORY SURGICAL CENTERS

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

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

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

EMERGENCY ROOM

in a Non-Medical Emergency or Non-Serious Accidental Injury

Participating Provider

30% of the Negotiated Fee Rate.

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. The Copayment for this benefit **will not** be applied toward the Insured's Participating and Non-Participating Provider Yearly Copayment/Coinsurance Maximums.

EMERGENCY ROOM

in a Medical Emergency or Serious Accidental Injury

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

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

30% of the Negotiated Fee Rate.

Emergency Room services received in the state of California are subject to an additional \$100 Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. The Copayment for this benefit **will not** be applied toward the Insured's Participating and Non-Participating Provider Yearly Copayment/Coinsurance Maximums.

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 combined.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider
and out of state provider

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

AMBULANCE

IN A MEDICAL EMERGENCY OR WITH AN AUTHORIZED REFERRAL

Participating Provider

Ground Ambulance:
30% of the Negotiated Fee Rate.

Air Ambulance:
30% of the Negotiated Fee Rate.

Non-Participating Provider

Ground Ambulance:
30% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

Air Ambulance:
30% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

AMBULANCE

OTHER THAN IN A MEDICAL EMERGENCY OR WITHOUT AN AUTHORIZED REFERRAL

Participating Provider

Ground Ambulance:
30% of the Negotiated Fee Rate.

Air Ambulance:
30% of the Negotiated Fee Rate.

Non-Participating Provider

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

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

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

OFFICE VISITS

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

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

WELL BABY AND WELL CHILD CARE

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.

PREVENTIVE CARE

Participating Provider	0% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate plus any charges in excess of the Negotiated Fee.

MEDICAL SUPPLIES and EQUIPMENT

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

FOOTWEAR

Benefits are limited to a maximum Anthem payment of \$5,000 per Year, combined for Participating and Non-Participating Providers.

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND/OR SPEECH THERAPY

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

CHIROPRACTIC CARE

Benefits are limited to 20 visits per Year, combined for Participating and Non-Participating Providers.

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

DENTAL INJURY

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

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child. 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 Insured's Participating and Non-Participating Provider Yearly Copayment/Coinsurance Maximums.

Inpatient Hospital and Day Treatment Program

Participating Provider	30% of the Negotiated Fee Rate.. 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. Limited to 30 days per Year. After 30 days, you pay all charges for the remainder of that Year.

Professional Services

(Inpatient and Outpatient Physician Services)

Participating Provider	30% of the Negotiated Fee Rate. 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. Limited to 1 visit per day and 20 visits per Year.

BENEFIT

YOUR PAYMENT RESPONSIBILITY

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.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

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

SMOKING CESSATION PROGRAM

Participating Provider

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.

Non-Participating Provider

Not covered

FOREIGN COUNTRY PROVIDERS

For initial treatment of a Medical Emergency only.

All providers

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

30% of Customary and Reasonable Charges **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.

INFUSION THERAPY

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

Administrative and Professional Services:
All charges in excess of \$50 per day.

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

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

BENEFIT

YOUR PAYMENT RESPONSIBILITY

HOME HEALTH CARE

Limited to ninety (90) visits per Year for Participating and Non-Participating Providers combined up to four (4) hours or less each visit.

Participating Provider

30% of the Negotiated Fee Rate.

Non-Participating Provider

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

HOSPICE

Participating Provider

30% of the Negotiated Fee Rate.

Non Participating Provider

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

SPECIAL CIRCUMSTANCES

Authorized Referral

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

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

For Medical Emergencies Within California

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

Non-Participating Provider

Professional Services:

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

Non-Participating Provider

Hospitals and Non-Contracting Hospitals:

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

Ambulatory Surgical Centers:

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

Ground Ambulance:

30% of the Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable unless **Special Circumstances** apply.

Air Ambulance:

30% of the Customary and Reasonable Charges **plus** all charges in excess of Customary and Reasonable unless **Special Circumstances** apply.

BLUECARD PROGRAM

For Medical Services Outside California

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

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

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

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

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

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

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

BlueCard Provider Types

PPO Providers

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

Traditional Providers

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

Non-Participating Providers

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

To locate a BlueCard PPO or Traditional provider when outside of California call 1-800-810-BLUE (2583) or visit the BlueCard 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 California

Physician

PPO Provider

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Traditional Provider*

50% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Non-Participating Provider

50% of the BlueCard provider Negotiated Price **plus** all charges in excess of the BlueCard providers Negotiated Price once your Deductible is satisfied.

Hospital or Ambulatory Surgical Center

PPO Provider

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Traditional Provider*

50% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Non-Participating Provider

Hospital:

You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense

Ambulatory Surgical Centers:

You pay 50% of Covered Expense **plus** all charges in excess of Covered Expense

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

Medical Emergencies Outside California

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

Physician

PPO Provider

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Traditional Provider

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Non-Participating Provider

30% of the Customary and Reasonable Charge **plus** all charges in excess of Customary and Reasonable once your Deductible is satisfied.

BENEFIT

Hospital or Ambulatory Surgical Center

PPO Provider

Traditional Provider

Non-Participating Provider

YOUR PAYMENT RESPONSIBILITY

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

30% of the BlueCard provider's Negotiated Price once your Deductible is satisfied.

Hospital:

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

Ambulatory Surgical Centers:

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

COMPREHENSIVE BENEFITS: WHAT IS COVERED

COVERED SERVICES

Before we pay for any benefits, you must satisfy your Deductible. The medical Deductible is described in the section Deductible under the 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 where indicated below.

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

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

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

SKILLED NURSING FACILITIES

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

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

AMBULANCE

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

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

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

OFFICE VISITS

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

PROFESSIONAL SERVICES

- Services of a Physician, including surgeons and specialists.
- Services of an anesthesiologist or anesthetist.
- Outpatient diagnostic radiology and laboratory services.
Note: The following procedures require Preservice Review.
 - Computerized Tomography (CT) scan
 - Positron Emission Tomography (PET) scan
 - Magnetic Resonance Imaging (MRI) scan
 - Magnetic Resonance Spectroscopy (MRS) scan
 - Nuclear Cardiology (NC) scan
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the Office Visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This includes screening for breast, cervical, ovarian and prostate cancer.
- Mammogram examinations and the Office Visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife.
- Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Prosthetic devices to achieve symmetry after mastectomy.
- The first pair of contact lenses or eyeglasses, when required as a result of covered eye surgery.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- Injectable contraceptives, except Norplant, when administered in a Physician's office.
- FDA approved medications that may only be dispensed by a Physician.

- Hepatitis B and Varicella Zoster (chicken pox) vaccines and other appropriate vaccinations as recommended by the American Academy of Pediatrics for Dependents age 7 through 18 and the Office Visit associated with administering that vaccination when ordered by your Physician.
- Reconstructive Surgery is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible.
- Services of a Physician for diabetes education services.
- Services of a Physician or Dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.

LIMITED PROFESSIONAL SERVICES

- Physical Therapy, Occupational Therapy and/or Speech Therapy visits, when rendered by a Physician are limited to a maximum of 24 visits per Year combined for Participating and Non Participating Providers.
- Chiropractic Care visits are limited to a maximum of 20 visits per Year combined for Participating and Non Participating Providers.
- Outpatient Professional Mental or Nervous Disorders or Substance Abuse services are limited to 1 visit per day and 20 visits per Year combined for Participating and Non Participating Providers.

WELL BABY and WELL CHILD CARE

For Insureds up to and including 6 years of age for Office Visits and/or services received in a Physician's office.

- Childhood immunizations and the routine physical examination associated with the immunization.
- Medically appropriate radiology services, laboratory tests and procedures in connection with the examination, including screening of blood lead levels for children at risk for lead poisoning.
- Routine hearing and vision tests.

PREVENTIVE CARE HEALTHYCHECK CENTERS

Insureds age 7 to adult

No Deductible is required however Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your Yearly Deductible.

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

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

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

The following services are 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
- Diphtheria booster

- Tetanus-Diphtheria and Pertussis booster
- Flu shot (per CDC guidelines and availability)

For adults only:

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

For children only:

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

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.

PHYSICAL EXAM (for Insureds age 7 to adult)

- Routine physical exams, and
- Medically appropriate laboratory tests and procedures, and radiology procedures, in connection with the examination.

Adult Preventive Services

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

TREATMENT FOR DIABETES

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

Diabetes Equipment and Supplies

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

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

Diabetes Outpatient Self-Management Training Program

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

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

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

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

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

MEDICAL SUPPLIES AND EQUIPMENT

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

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

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

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

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

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND/OR SPEECH THERAPY

Physical Therapy and Occupational Therapy include the therapeutic use of heat, cold, exercise, electricity, ultraviolet, manipulation of the spine, massage to improve circulation, strengthen muscles, encourage return of motion, or treatment of illness or injury. Speech Therapy is the treatment of speech defects and disorders through the use of exercises and audio-visual aids that develop new speech habits.

Benefits for Physical Therapy, Occupational Therapy and/or Speech Therapy are payable only for services rendered by a Physician. Benefits for these services are limited to a maximum of 24 visits per Year, combined for Participating and Non-Participating Providers.

CHIROPRACTIC CARE

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

Benefits for Chiropractic Care are payable only for services rendered by a Physician Benefits for these services are limited to a maximum of 20 visits per Year, combined for Participating and Non-Participating Providers.

DENTAL

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

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE, INCLUDING TREATMENT FOR SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD (Preservice Review is required for Facility Based Treatment. Preservice Review is also required for outpatient professional services after the twelfth (12th) visit.)

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

Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illnesses and Serious Emotional Disturbances of a Child will be provided at the same levels of coverage as other medical diagnoses. These services are subject to all other terms, conditions, limitations and exclusions, including MAXIMUM COMPREHENSIVE BENEFITS.

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").

WIGS

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

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.

PHENYLKETONURIA (PKU)

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

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

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

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

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

INFUSION THERAPY

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

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

Covered Services include:

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

Infusion Therapy benefits will not be provided for:

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

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

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

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

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

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

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

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

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

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

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

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

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

- We will review it and decide if we will approve benefits within 72-hours. (As soon as we can, based on your medical condition, as medically necessary, we may take less than 72-hours to decide if we will approve benefits.) We will tell you and your physician what we have decided - by telephone and in writing by facsimile to your physician, and in writing by mail to you.

- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your physician, within 24-hours after we get the request, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 24-hours, we will tell your physician that there is a problem as soon as we know that we cannot respond within 24-hours. In either event, we will tell you and your physician that there is a problem – in writing by facsimile, and by telephone, to your physician, and in writing by mail to you.
- As soon as we can, based on your medical condition, as medically necessary, but, not more than 48-hours after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to the physician and by mail to you. If the request is not for urgently needed drugs, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:
 - Based on your medical condition, as medically necessary, we will review it and decide if we will approve benefits within 5-business days. We will tell you and your physician what we have decided in writing - by fax to your doctor, and by mail, to you.
 - If more information is needed to make a decision, we will tell your physician in writing within 5-business days after we get the request what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your physician what information is missing within 5-business days, we will tell your physician that there is a problem as soon as we know that we cannot respond within 5-business days. In any event, we will tell you and your physician that there is a problem by telephone, and in writing by facsimile, to your physician, and in writing to you by mail.
 - As soon as we can, based on your medical condition, as medically necessary, within 5-business days after we have all the information we need to decide if we will approve benefits, we will tell you and your physician what we have decided in writing - by fax to your physician and by mail to you. While we are reviewing the request for a specialty pharmacy drug, a 72-hour emergency supply of medication may be dispensed to you if your physician determines that it is appropriate and medically necessary. You may have to pay the applicable Copayment, if any, shown in the part entitled BENEFIT COPAYMENT/COINSURANCE LIST for the 72-hour supply of your drug. If we approve the request for the specialty pharmacy drug after you have received a 72-hour supply, you will receive the remainder of the 30-day supply of the drug after payment of any applicable additional Copayment that could apply.

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

If we deny a request for prior authorization of a specialty pharmacy drug, you or your prescribing physician may appeal our decision by calling us at 1-800-700-2533. If you are not satisfied with the resolution based on your inquiry, you may file a grievance with us by following the procedures described in the section entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES.

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

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

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

Urgent or emergency need of a specialty pharmacy drug subject to the specialty pharmacy program.

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

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

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

CANCER CLINICAL TRIALS

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

The treatment provided in a clinical trial must either:

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

Covered Services include:

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

Covered Services will not include the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that an Insured may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or services that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Policy.
- Health care services customarily provided by the research sponsors free of charge to Insureds enrolled in the trial.

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

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

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

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

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures.

Preservice Review can be obtained by calling toll free 1-800-274-7767. When you or your Physician calls for the required Preservice Review, we will advise you that such services must be performed at an Anthem CME.

Note: Charges for these bariatric surgical procedures and related services are covered only when the bariatric surgical procedure and related services are approved by Anthem and performed 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 Insured's home is fifty (50) miles or more from the nearest bariatric CME. All travel expenses must be approved by Anthem in advance.

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

CUSTOMER SERVICE WILL CONFIRM IF THE BARIATRIC TRAVEL BENEFIT IS PROVIDED IN CONNECTION WITH ACCESS TO THE SELECTED BARIATRIC CME. DETAILS REGARDING REIMBURSEMENT CAN BE OBTAINED BY CALLING THE CUSTOMER SERVICE TOLL FREE AT 1-800-333-0912. A TRAVEL REIMBURSEMENT FORM WILL BE PROVIDED FOR SUBMISSION OF LEGIBLE COPIES OF ALL APPLICABLE RECEIPTS IN ORDER TO OBTAIN REIMBURSEMENT.

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

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

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

- The recipient or
- The donor.

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

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

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

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

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

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

Travel expenses that are not covered include, but are not limited to: 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 will not exceed \$30,000 per transplant.

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

HOME HEALTH CARE

Home Health Care providers are included in our Participating Provider Network. The following services of a Home Health Agency or Visiting Nurse Association are provided up to ninety (90) visits per Year for Participating and Non-Participating Providers combined. A visit is defined as four (4) hours or less of service provided by one of the providers listed below.

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

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

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

HOSPICE

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

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

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

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

EXCLUSIONS AND LIMITATIONS

We will not furnish benefits for:

Acupuncture/Acupressure

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

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

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

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

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

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

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

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

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

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

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

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

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

Hearing Aids: Hearing aids and routine hearing tests.

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

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

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

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

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

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

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Agreement.
- 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.
- 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 by Medicare Part D.

Non-licensed Providers: Services provided by non-licensed Providers.

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

Not Medically Necessary: Any services or supplies that are:

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

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

Outdoor Treatment Programs

Outpatient Drugs and Medications: Outpatient prescription Drugs, medications, insulin or other substances dispensed or administered in any outpatient setting except as specifically stated under the PARTS entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED and YOUR PRESCRIPTION DRUG BENEFITS.

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

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

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

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

Routine Physical Exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority except as specifically stated in the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

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

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

Services that do not Require Licensure: Services or the supervision of services that are not required to be rendered by a licensed Provider 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 change.

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

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **You will have to pay the full cost of the specialty pharmacy drugs you get from a retail pharmacy that you should have purchased from the specialty pharmacy program.**

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

Telephone and Facsimile Machine Consultations

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 Policy as Covered Services.

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

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

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

YOUR PRESCRIPTION DRUG BENEFITS

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

Anthem 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 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 Prescription Drug Formulary, please call toll free 1-800-700-2533.

Some medications may require Prior Authorization from Anthem. Please call the Pharmacy Benefits Manger toll free 1-800-700-2533 for a list of these Drugs.

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

DEFINITIONS

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 (FDA) for general use by the public. For purposes of this benefit, Insulin will be deemed a Prescription Drug.

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

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

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

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

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Call your local Pharmacy or call the customer service at 1-800-700-2533. Some Participating Pharmacies display an Anthem "Rx" decal so that you can easily identify them.

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

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

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

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

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

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

Tier-3 drugs - means a drug that has a higher copayment and/or coinsurance than those on Tier 2. This tier will contain non-preferred or high cost medications. This Tier may include generic, single source brand drugs or multi-source brands drugs.

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

DRUG UTILIZATION REVIEW

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. Also, a Participating Pharmacist can help arrange prior authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

PRIOR AUTHORIZATION

Certain Drugs require written prior authorization for you to obtain benefits even if the prescribing doctor writes "do not substitute" or "dispense as written" on the Prescription. Prior authorization criteria will be based on medical policy, clinical guidelines and established pharmacy and therapeutic guidelines. If you have any questions whether a Drug is on our preferred Drug list or require prior authorization, please call 1-800-700-2533.

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

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

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

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

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

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

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

If you have any questions whether a Drug is on our preferred Drug list or 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 policy ends;
- You reach a benefit maximum that applies to prescription drugs, if the plan includes such a maximum;
- Your prescription drug benefits under the policy change so that prescription drugs are no longer covered or are covered in a different way.

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

TIER 2, TIER 3 AND SPECIALTY PRESCRIPTION DRUG DEDUCTIBLE

Each Insured must meet a Tier 2, Tier 3 and Specialty Prescription Drug Deductible amount of \$500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical Participating or Non Participating Provider Deductibles. This Tier 2, Tier 3 and Specialty Prescription Drug Deductible apply to Tier 2, Tier 3 and Specialty Prescription Drugs purchased through Participating Pharmacies, the Mail Order Prescription Drug Program or through Specialty Preferred Provider. However, any Copayment made for a Tier 2 or Tier 3 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 or Tier 3 Drug will **not** be applied towards the Tier 2, Tier 3 and Specialty Prescription Drug Deductible.

SPECIALTY PRESCRIPTION DRUG COINSURANCE MAXIMUM

There is a \$2,500 Specialty Prescription Drug Coinsurance Maximum for Specialty Prescription Drugs per Insured per Year purchased from Participating Pharmacies or through our Specialty Preferred Provider. The first month supply of a Specialty Drug is available through a Participating Pharmacy. Once the \$2,500 Specialty Prescription Drug Coinsurance Maximum is met, no further Specialty Prescription Drug Coinsurance Maximum will be required for Specialty Prescription Drugs purchased through Participating Pharmacies, or through our Specialty Preferred Provider for the remainder of that Year. Copayments for Tier 1, Tier 2 and Tier 3 Drugs and the Tier 2, Tier 3 and Specialty Drug Deductible **will not** accumulate towards the Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Specialty Prescription Drug Coinsurance Maximum has been reached.

WHAT IS COVERED

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

- Outpatient Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Injectable Insulin and Insulin syringes prescribed and dispensed for use with Insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Prescriptions which contain at least one covered Prescription ingredient.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction are covered only after the Insured has been covered under this Policy for twelve (12) consecutive months. These Drugs and medications must be authorized in advance by the Anthem and are limited to eight (8) tablets/units per thirty (30) day period. **(Not covered under mail order Prescription Drug program).**
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Tier 2 Drugs and the Tier 2, Tier 3 and Specialty Prescription Drug Deductible.

Note: Tier 1 Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Tier 2 or Tier 3 Drug and states “dispense as written” or “no substitutions”, or no Tier 1 Drug equivalent exists. However, any Copayment made for a Tier 2 or Tier 3 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 or Tier 3 Drug will **not** be applied towards the Tier 2, Tier 3 and Specialty Prescription Drug Deductible.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program, or through our specialty pharmacy program within one (1) year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration (FDA).
- Be for the direct care and treatment of the Insured’s illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy, dispensed by a Physician or ordered by mail through the mail order program.
- Not be used while the Insured is an inpatient in any facility.
- Be dispensed by a participating pharmacy if it is an approved compound medication. You may call 1-800-700-2541 or go to www.anthem.com/ca to find out where to take your prescription for an approved compound medication to be filled.

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

- Be dispensed by the specialty pharmacy program if it is a specialty pharmacy drug. See the section Specialty Drug Fulfillment in this part for how to get your drugs by using the specialty pharmacy program.

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

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

WHEN YOU GO TO A PARTICIPATING PHARMACY

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

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

For Prescription Drugs on the Anthem Formulary:

These benefits apply only to Prescription Drugs listed on the Plan Formulary. Drugs not shown on the Plan Formulary are not covered and you will be responsible for the full cost of a drug that is not on the Plan Formulary. Anthem discounts will apply to non-formulary drugs.

PARTICIPATING RETAIL PHARMACY:

For Drugs on the Prescription Drug Formulary:

- **Tier 1 Drugs:** \$15 Copayment
- **Tier 2 Drugs:** 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied:
 - \$40 Copayment if a Tier 1 equivalent is not available. If a Tier 1 equivalent is available, \$40 Copayment **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 2 Drug and the Tier 1 Drug equivalent.
- **Tier 3 Drugs:** 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: \$60 Copayment for the Tier 3 Drug if a Tier 1 equivalent is not available. If a Tier 1 equivalent is available, \$60 Copayment **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount when purchased at a Participating Pharmacy, between the Tier 3 Drug and the Tier 1 Drug equivalent.
- **Specialty Drugs:** 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Prescription Drug Maximum Allowed Amount.

Specialty Drugs available only through our Specialty Drug Provider. See the section entitled ‘Specialty Pharmacy Program’ for more information: 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Prescription Drug Maximum Allowed Amount. Specialty Drugs are available only through our Specialty Preferred Provider. Please see the section entitled ‘Specialty Pharmacy Program’ for more information on ordering Specialty Drugs. Specialty Drugs are limited to a 30-day supply per fill.

Self-Administered Injectable Drugs:

Generic Self-Administered Injectable Drugs: 25% 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 for Insulin.

Brand Self-Administered Injectable Drugs: 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: 25% of the Prescription Drug Maximum Allowed Amount. Any Copayments made for a Specialty Self-Administered Injectable Drugs will apply towards the Specialty Prescription Drug Coinsurance Maximum.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

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

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

WHEN YOU ORDER BY MAIL

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

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

Tier 1 Drugs: You pay a \$45 Copayment for each Prescription and/or refill for each ninety (90) day supply.

Tier 2 Drugs: 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: you pay a \$120 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available. If a Tier 1 equivalent is available, you pay a \$120 Copayment **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount between the Tier 2 Drug and the Tier 1 Drug equivalent for each Prescription and/or refill for each ninety (90) day supply.

Tier 3 Drugs: 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 per Insured Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied: you pay a \$180 Copayment for each Prescription and/or refill for each ninety (90) day supply if a Tier 1 equivalent is not available. If a Tier 1 equivalent is available, you pay a \$180 Copayment **plus** the difference in cost, based on the Prescription Drug Maximum Allowed Amount between the Tier 3 Drug and the Tier 1 Drug equivalent for each Prescription and/or refill for each ninety (90) day supply.

Specialty Drugs available only through our Specialty Drug Provider. See the section entitled Specialty Pharmacy Program for more information: 100% of the Prescription Drug Maximum Allowed Amount per Insured per Year until the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied. After the \$500 Tier 2, Tier 3 and Specialty Prescription Drug Deductible has been satisfied then 25% of the Prescription Drug Maximum Allowed Amount. Specialty Drugs are available only through our Specialty Preferred Provider. Please see the section entitled 'Specialty Pharmacy Program' for more information on ordering Specialty Drugs. Specialty Drugs are limited to a 30-day supply per fill.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

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

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy Program

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

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

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

When You Order Your Prescription Through the Specialty Preferred Provider.

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

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

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

Attn: 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 Pharmacy Program, you will not receive any benefits for them under this policy. You will have to pay the full cost of any Specialty Drugs you get from a retail pharmacy that you should have obtained from the Specialty Preferred Provider. Please note that Specialty Drugs are not covered 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:

The first month supply of a specialty drug which is available through a Participating Pharmacy; Drugs, which due to medical necessity, are needed urgently and must be administered to the Insured immediately.

HOW TO OBTAIN AN EXCEPTION TO THE SPECIALTY PHARMACY PROGRAM

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

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

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

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

SPECIAL PROGRAMS

Special Programs

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

Half-Tablet Program

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

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

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

Prescription drugs will always be dispensed as ordered by the member's provider and by applicable State Pharmacy Regulations, however the member may have higher out-of-pocket expenses. The member may request, or the member's provider may order, a brand-name drug. However, if a Tier 1 Drug is available, the member will be responsible for the cost difference between the Tier 1 and the Tier 2 or Tier 3 Drug, in addition to the member's Tier 1 copayment and/or coinsurance. By law, Tier 1 and Tier 2 or Tier 3 Drugs must meet the same standards for safety, strength, and effectiveness and are typically lower in cost. Anthem reserves the right, at its discretion, to remove certain higher cost generic drugs for this policy.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

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

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

- All Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction are covered only after the Insured has been covered under this Policy for twelve (12) consecutive months. Treatment of impotence and/or sexual dysfunction must be Medically Necessary and evidence of a contributing medical condition must be submitted to Anthem Blue Cross Life and Health Pharmacy Plan for review. Drugs and medications for the treatment of impotence and/or sexual dysfunction are limited to eight (8) tablets/units per thirty (30) day period. (Not covered under mail order program).
- A Prescription dispensed in excess of a thirty (30) day supply, (unless ordered by mail through the Mail Order Prescription Drug Program, in which case the limit is a ninety (90) day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.
- Compound medications obtained from other than a participating pharmacy. You will have to pay the full cost of the compound medications you get from a non-participating pharmacy.
- Specialty pharmacy drugs that must be obtained from the Specialty Pharmacy Program but which are obtained from a retail pharmacy. You will have to pay the full cost of the Specialty Pharmacy Drugs you get from a retail pharmacy that you should have filled through the Specialty Pharmacy Program.

CLAIMS AND CUSTOMER SERVICE

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

Anthem Prescription Drug Program

P.O. Box 4165

Woodland Hills, CA 91365-4165

or call the toll free customer service phone number at 1-800-700-2533

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

Anthem Mail Order Prescription Drug Program

P.O. Box 746000

Mason, OH 45274

or call the toll free customer service phone number at 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 Policy. All Covered Services are subject to review by Anthem for medical necessity.

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

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

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

Revoking or modifying an authorization.

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

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

Preservice Review is required for, but not limited to:

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

Admission Review. Anthem will determine at the time of admission if the service is Medically Necessary in the event Preservice Review is not conducted (except for inpatient Hospital stays related to 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 any service was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

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

ALTERNATIVE BENEFITS

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

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

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

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

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

Alternative benefits paid are accumulated toward any annual Maximums under the Policy.

GENERAL PROVISIONS

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

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

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

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

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

- Please contact customer service toll free at 1-800333-0912 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Policy.

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

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

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

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

Out of California Providers: The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows our Insureds to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If you have any questions or complaints about the Blue Card Program, please call us at 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 Policyholder liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state mandate Policyholder liability calculation methods that differ from the usual BlueCard method noted above in the preceding paragraph of this item or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

When traveling outside the United States, in cases of emergencies only, call 1-800810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

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

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

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

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

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

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

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

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

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

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

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

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

Terms of Coverage:

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

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

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

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

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If an Insured has had any Covered Service denied, modified or delayed or has had coverage denied because proposed treatment is determined by us to be investigational or experimental, or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external, independent medical review organization. To request a review, please call 1-800333-0912 or write to us at Anthem Blue Cross Life and Health Insurance Company P.O. Box 9051 Oxnard, California 93031-9051. To request an Independent Medical Review (IMR) from the California Department of Insurance (DOI), all of the following conditions must be satisfied:

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

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

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

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

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

“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,
- Either of the following reference compendia: 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,
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

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

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

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

AND

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

General

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

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

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

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

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

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 POLICY OR ANY OTHER ISSUES RELATED TO THE POLICY 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.* YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

Please send all Binding Arbitration demands in writing to:

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

COMPLAINTS

If you have a complaint about services from Anthem or your health care provider, including your ability to access needed health care in a timely manner please call Anthem first at our customer service number toll free 1-800-333-0912. You may write to us at:

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

If you have any questions regarding your eligibility or membership, please contact our customer service department toll free at 1-800333-0912, or you may write to us at:

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

DEPARTMENT OF INSURANCE

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

Department of Insurance, Consumer Services Division
300 South Spring St., South Tower 11th Floor
Los Angeles, CA 90013
Toll-free phone number 1-800-927-HELP (4357)

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

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

The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed in addition to a \$50 reinstatement fee, and you will be subject to medical underwriting. See the section Reinstatement under the part entitled GENERAL PROVISIONS for information on our reinstatement provision.
 2. On the first of the month following our receipt of your written notice to cancel.
 3. For fraud or misrepresentation in certain situations. Misrepresentation or omissions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or misrepresentation will be effective as of the Effective Date of coverage in the case of rescission. Please see the part entitled ELIGIBILITY for information on continuing coverage for eligible Insureds on rescinded Policies.
 4. For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.
 5. Upon becoming ineligible for this coverage. See the part entitled WHEN AN INSURED BECOMES INELIGIBLE.

E. Notice to Cancel or Cease Coverage

1. Before we will cease to provide any new or existing individual health benefit Policy:
 - a. We will give you at least 180 days written notice prior to cessation of this Policy and
 - b. Those individual health benefit Policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under B. of this PART.
2. We will give you ninety (90) days written notice before we withdraw this individual health benefit Policy from the health care market.
3. In addition to the right to terminate, cancel or decline to renew the Policy set forth in Paragraph D., Anthem has the right upon renewal, or at any time during the duration of your Policy, to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that Anthem gives you sixty (60) days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, covered benefits, Deductibles, Copayments or coinsurance. Anthem can modify or change the terms and conditions of your Policy at any time during the Year on sixty (60) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.
 - a. In addition to the sixty (60) days written notice provision set forth above, Anthem's right to modify this Policy under Paragraph E. 3. is subject to the following conditions:
 - i. We will not cancel or modify this Policy under this Paragraph E., 3. on an individual basis but only for all Insureds in the same class and covered under the same Policy as you, except:
 - (a) if we discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by an individual,
 - (b) if we find out about any fraud or deception in the use of the benefits of this Policy by you, your enrolled family or anyone else if you or any Insured of your family knows about it.
 - ii. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph A. above) on or after the 60th day following the date of the above notice.

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

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

NON-DUPLICATION OF ANTHEM BENEFITS

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Cosmetic and Reconstructive Surgery: **Cosmetic Surgery** is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance, to the extent possible. Reconstructive Surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

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

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

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

Creditable Coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- licensed by the California Department of Health Services,
- qualified to provide short-term inpatient treatment according to state law,

- accredited by the Joint Commission on Accreditation of Health Care Organizations,
- staffed by an organized medical or professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

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

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

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

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

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

Medical Emergency as determined means a Psychiatric Emergency Medical Conditions 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 Insured's health in jeopardy or
- causing other serious medical or psychiatric consequences or
- causing serious impairment to bodily functions or
- causing serious and permanent dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

For purposes of this Definition, Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology and radiology) or any other services performed other than or in addition to any of the three services specifically listed above.

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

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

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

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

Physician means:

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

Special Circumstances means services that are received from a Non-Participating Provider with an Authorized Referral or in a Medical Emergency.

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

MONTHLY PREMIUMS

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

There are different billing options available:

Paper Bill:

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

Checking Account Deduction Program/Credit Card

- Monthly (1 month)

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

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

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

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

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

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.

Premium Changes: Premiums are the monthly charges the member must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the member's age and the specific regional area in which the member resides. If the member changes residence, he or she may be subject to a change in premiums. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the member does not notify Anthem of a change in residence and Anthem later learns of the change in residential address, Anthem may in its discretion bill the member for the difference in premium from the date the address changed. Anthem will recalculate your premium based upon the age of each Insured and your premium will be adjusted to the new rate prior to any other premium change. Anthem will send out written notification 60 days in advance of such change.

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

We reserve the right to change the premiums on sixty (60) days written notice to the Policyholder prior to the close of any billing term. The change will become effective on the date shown in the notice and payment of the new charges will indicate acceptance of the change.

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

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