



**ENDORSEMENT TO THE INDIVIDUAL
TONIK CONTRACTS**

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

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

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

1. The contract code for the Policy is changed to 06BK.
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 Coverage cannot be rescinded unless the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the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 After 24 months following issuance, the policy may not be rescinded for any reason.

If coverage of an individual is rescinded, written notice will be sent explaining the basis for the decision and the individual's appeal rights.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

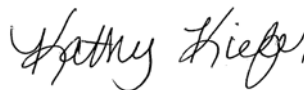
This Endorsement is part of your Anthem Blue Cross Life and Health Individual Policy. Please keep all of your documents together. This Endorsement terminates concurrently with the Policy to which it is attached.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY



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



Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company

ENDORSEMENT TO THE INDIVIDUAL TONIK POLICY

Tonik \$1,500 - DN13 (T773)

Tonik \$3,000 - DN14 (T774)

Tonik \$5,000 - DN15 (T775)

Issued by

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

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

Under the part entitled YOUR GENERIC PRESCRIPTION DRUG BENEFITS the language has changed to read as follows:

YOUR GENERIC PRESCRIPTION DRUG BENEFITS

We will provide outpatient Generic Prescription Drug benefits as explained in this PART, subject to all other terms, conditions, limitations and exclusions of this Policy. For the meaning of a term, which appears with the first letter of each word in capital letters, look at the PRESCRIPTION DRUG DEFINITIONS section at end of this PART.

Anthem uses a preferred list of Drugs, sometimes called a formulary, to help your doctor make prescribing decisions. Your Prescription Drug benefits cover only Generic Prescription Drugs listed in the Blue Cross Generic Prescription Drug Formulary. This list of Drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes Generic Drugs that are safe and effective in the treatment of disease.

If you have a question regarding whether a Generic Drug is listed on the Blue Cross Generic Prescription Drug Formulary, please call ~~WellPoint NextRx~~ [the Pharmacy Benefits Manager](#) toll free at **(800) 700-2533**. For your convenience, the Blue Cross Generic Prescription Drug Formulary can be accessed online at tonikhealth.com or if you would like a copy of the Formulary, please contact us at **(866) 333-4820**.

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the section called Non-Duplication of Medicare under the PART called WHAT IS NOT COVERED.

WHEN YOU GO TO A PARTICIPATING PHARMACY

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

- **Generic Drugs:** \$15 Copayment.
- **Self-Administered Injectable Drugs:** 30% of the ~~Negotiated Fee~~ [Prescription Drug Maximum Allowed Amount](#) for Self-Administered Injectable Drugs listed on the Blue Cross Generic Prescription Drug Formulary, except for insulin.

WHEN YOU ORDER BY MAIL

Your mail service prescription drug program is administered by ~~PrecisionRx~~ [Pharmacy Benefits Manager](#). Your mail service Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Maintenance Drugs, an ongoing Generic Prescription listed on the Blue Cross Generic Prescription Drug Formulary, can be purchased by mail, requiring the following Copayment to be submitted for each Prescription:

- **Generic Drugs:** You pay a \$15 Copayment for each Prescription and/or refill for each 30-day supply, or a \$30 Copayment for up to a maximum 60-day supply.

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail service prescription drug program including, but not limited to, antibiotics, Drugs that are not listed on the Blue Cross Generic Prescription Drug Formulary, and injectables, including Self-Administered Injectables except insulin. Please check with the [PrecisionRx Pharmacy Benefits Manager](#) customer service department at (866) 274-6825 for availability of the Drug or medication.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

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

~~WellPoint NextRx~~
~~Attn:~~ Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Claim forms are available on our website tonikhealth.com or call customer service at (800) 700-2533. Mail the claim form, with the appropriate portion completed and signed by the pharmacist, to Anthem no later than fifteen (15) months after the date of dispensing.

- **The rate of reimbursement by Anthem when your covered Generic Prescription is filled at a Non-Participating Pharmacy** will be 50% of the ~~Drug Limited Fee Schedule amount~~ [Prescription Drug Maximum Allowed Amount](#) less the Copayment/Coinsurance as stated for Participating Pharmacies.

CLAIMS AND CUSTOMER SERVICE

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

~~WellPoint NextRx~~
~~Attn:~~ Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

or call the toll free customer service phone number at (800) 700-2533.

For **mail service prescription drug program** inquires, please check the website at www.precisionrx.anthem.com or write to:

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

or call the toll free customer service phone number at (866) 274-6825.

WHAT IS COVERED

If listed on the Blue Cross Generic Prescription Drug Formulary, the following Generic Prescription Drugs are covered under this PART.

- Outpatient Generic Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin and insulin syringes prescribed and dispensed for use with insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Generic Prescriptions which contain at least one covered Prescription ingredient.
- Oral contraceptive Generic Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA-approved Prescription contraceptive method will be provided.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be a Generic form of the Prescription and listed on the Blue Cross Generic Prescription Drug Formulary.
- Be prescribed in writing by a Physician and be dispensed within one (1) year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration (FDA).
- Be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy, dispensed by a Physician or ordered by mail through the mail service prescription drug program.
- Not be used while you are an inpatient in any facility.

Note: We will provide Prescription Drug benefits up to a 30-day supply for each 30-day period (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 60-day supply).

DRUG UTILIZATION REVIEW

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

Revoking or modifying a prior authorization

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

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

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

WHAT IS NOT COVERED UNDER YOUR PRESCRIPTION DRUG BENEFITS

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

- Prescription Drugs that are not listed on the Blue Cross Generic Prescription Drug Formulary.
- Brand Name Drugs, except as listed on the Blue Cross Generic Prescription Drug Formulary.

- Drugs or medications which may be obtained without a Physician's Prescription, except insulin and Niacin for cholesterol lowering.
- All Prescription and non-Prescription herbs, botanicals and nutritional supplements which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a disease.
- Non-medicinal substances or items **including** pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any Prescription product containing nicotine. However, please see available benefits described in the PROGRAMS TO STOP SMOKING section under the PART called BENEFITS SUMMARY.
- 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.
- Drugs taken while you are in a Hospital, Skilled Nursing Facility, rest home, sanatorium, convalescent Hospital or similar facility.
- Any expense incurred in excess of the ~~Anthem Negotiated Fee~~ [Prescription Drug Maximum Allowed Amount](#) at a Participating Pharmacy.
- ~~Any expense incurred in excess of billed charges or the Average Wholesale Price, whichever is less, at a Non-Participating Pharmacy.~~
- Any drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications, for example, progesterone suppositories.
- Syringes and/or needles except those dispensed for use with insulin.
- Durable medical equipment, devices, appliances, and supplies except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen.
- Professional charges in connection with administering, injecting or dispensing Drugs. Infusion medications.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities, doctors' offices and home IV therapy.
- Drugs used for cosmetic purposes, for example, Retin-A for wrinkles and Rogaine for hair growth.
- Drugs and medications used for pregnancy, maternity care or abortion. However, oral contraceptives are covered as specifically stated in the section called 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 the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Policy except where specifically stated under the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.
- A Prescription dispensed in excess of a 30-day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 60-day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

PRESCRIPTION DRUG DEFINITIONS

~~Average Wholesale Price (AWP) is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.~~

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

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

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 (Blue Cross Generic Prescription Drug Formulary) is a list of Drugs which Anthem has determined to be safe and cost-effective based on available medical literature. This Formulary is used by Blue Cross of California and its affiliate, Anthem Blue Cross Life and Health Insurance Company.

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

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

~~Negotiated Fees are the fees that Anthem has negotiated with the Participating Pharmacies under Participating Pharmacy agreements for covered Prescriptions. Participating Pharmacies have agreed to charge you no more than the Negotiated Fees for covered Generic Prescriptions.~~

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy. Please see the section called WHEN YOU GO TO A NON-PARTICIPATING PHARMACY for information on the percentage payable at a Non-Participating Pharmacy.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. To identify a Participating Pharmacy, call your local Pharmacy directly or call WellPoint NextRx toll free at (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 \(800\) 700-2533.](#)

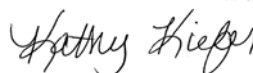
Self-Administered Injectable Drugs are injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY



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



Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health
Insurance Company

ENDORSEMENT TO THE INDIVIDUAL TONIK POLICY

Tonik \$1,500 DN13 (T773)

Tonik \$3,000 DN14 (T774)

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ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

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

I. Under the PART entitled WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE the following changes have been made:

Under the section entitled PREMIUMS the 1st paragraph has changed to read as follows:

Premiums are the monthly charges the Policyholder must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the Policyholder's age and the specific regional area in which the Policyholder resides. If the Policyholder changes residence, he or she may be subject to a change in premiums, ~~without prior written notice from Anthem~~. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the Policyholder 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 Policyholder for the difference in premium from the date the address changed. Anthem will recalculate your premium based upon the age of the Policyholder ~~on your Policy Anniversary Date~~ and your premium will be ~~automatically~~ adjusted to the new rate prior to any other premium change. ; Anthem will send out written notification 30 days in advance of such change.

Under the same section, the 3rd paragraph has changed to read as follows:

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

Under the section entitled, HOW YOUR COVERAGE ENDS the 2nd paragraph under item 1. has changed to read as follows:

The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed in addition to a \$50 reinstatement fee, and you will be subject to medical underwriting. See the section REINSTATEMENT in the PART called IMPORTANT INFORMATION ABOUT YOUR PLAN for the reinstatement provision.

Under the same section, the following language has been added as item 6.:

6. When you move to and live in a place outside of California.

II. Under the part entitled HOW YOUR PLAN WORKS WHEN YOU NEED CARE under the section entitled WHAT IS YOUR LIFETIME MEDICAL BENEFIT MAXIMUM the following the following language has been added as the 2nd paragraph:

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

III. Under the part entitled **BENEFITS SUMMARY** under the **BENEFITS SUMMARY LIST**, the following changes have been made:

Under the section entitled, **Mental Health Care and Substance Abuse**, under the subsection entitled, 'Inpatient Hospital and Day Treatment Program,' in the 4th column under 'Information You Should Know,' the following language has been added as the 3rd paragraph:

[Preservice review required for all facility based treatment, as well as outpatient professional services after the twelfth \(12th\) visit.](#)

Under the same subsection, the following language has been added in the same column as the 5th paragraph:

[Preservice review required for outpatient professional services after the twelfth \(12th\) visit and all facility based treatment.](#)

Under the section entitled, **SKILLED NURSING FACILITY**, in the 4th column, the 2nd paragraph has been changed to read as follows:

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

Under the section entitled, **SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA**, under the subsection 'Hospital and Non-Contracting Hospital,' the language has changed and the paragraph in the 4th column under 'INFORMATION YOU SHOULD KNOW' has been removed as illustrated below:

Hospital and Non-Contracting Hospital:

You pay all charges ~~in excess of Covered Expense for the first 48 hours. After 48 hours, you pay all charges except \$650 per day.**~~

~~**If you can demonstrate to Blue Cross and/or Blue Shield that your medical condition reasonably prevented transfer to a BlueCard PPO or Traditional facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a PPO or Traditional facility.~~

IV. Under the part entitled, **WHAT IS COVERED**, the following changes have been made.

Under the section entitled **MENTAL HEALTH CARE AND SUBSTANCE ABUSE** the language has been deleted and moved to be combined with **SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD** and will read as follows:

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

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

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

[Severe Mental Illness and Serious Emotional Disturbances of a Child:](#)

Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child will be provided at the same levels of coverage as other medical diagnoses. These services are subject to all other terms, conditions, limitations and exclusions, stated in this Policy including Deductibles and maximum amounts described in the PARTS called HOW YOUR PLAN WORKS WHEN YOU NEED CARE and BENEFITS SUMMARY. **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.](#) See the PART called IMPORTANT TERMS TO KNOW for a definition of Severe Mental Illness and Serious Emotional Disturbances of a Child.

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

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

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

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a CME facility. Information on CME facilities can be obtained by calling **1-866-333-4820**.

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed ~~by~~ 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 procedures and related services are approved by Anthem and performed at an Anthem CME facility. ~~Preservice Review is required.~~

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Policyholder's home is 50 miles or more from the nearest bariatric CME. All travel expenses must be approved by Anthem in advance.

- Transportation for the Policyholder to and from the CME up to \$130 per trip for a maximum of three (3) trips (one (1) pre-surgical visit, the initial surgery and one (1) follow-up visit).
- Transportation for one companion to and from the CME up to \$130 per trip for a maximum of two (2) trips (the initial surgery and one (1) follow-up visit).
- Hotel accommodations for the Policyholder 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 Policyholder's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Meals, ~~T~~obacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at 1-866-333-4820. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

~~**Organ and Tissue Transplants (requires Preservice Review):** You or your Physician must obtain Preservice Review for all services including, but not limited to preoperative tests and postoperative care related to the following specified ~~organ and tissue~~ transplants: (heart, liver, lung, combination heart/lung, kidney, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral/stem cell ~~replacement~~ and similar procedures). Specified transplants must be performed at a Center of Medical Excellence (CME). Charges for services are 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~~ initiated by calling toll free 1-888-613-1130.**~~

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

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

- The ~~organ or tissue~~-recipient, or
- The ~~organ or tissue~~-donor.

~If you are the recipient, an organ or tissue donor who does not have coverage provided by Anthem or its affiliates is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

~~■ The Policyholder who needs to store cord blood and the storage is considered Medically Necessary according to the Anthem criteria for cord blood storage at an Anthem designated facility.~~

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

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

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

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

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

Unrelated Donor Searches

- For all charges for unrelated donor searches for covered Bone marrow/stem cell transplants will not exceed \$30,000 per transplant.

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

V. Under the PART entitled WHAT IS NOT COVERED the following terms have been added alphabetically or revised as follows:

COMMERCIAL WEIGHT LOSS

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

EDUCATIONAL, VOCATIONAL, AND TRAINING SERVICES AND NUTRITIONAL COUNSELING

except as specifically listed as being covered under the part ~~provided or arranged by us under the Diabetes Outpatient Self-Management Training Program provision in the PART~~ called WHAT IS COVERED.

FOOD AND/OR DIETARY SUPPLEMENTS

No benefits are provided for nutritional and/or dietary supplements except as provided in this Policy or as required by law for formulas and special food products as specifically stated under Phenylketonuria (PKU) in the PART called WHAT IS COVERED. They must be prescribed by a Physician in consultation with a metabolic disease specialist and deemed Medically Necessary to prevent complications of PKU. Coverage is only to the extent that the prescribed formulas and special food products exceed the cost of a normal diet. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

GOVERNMENT SERVICES

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

HEALTH CLUBS

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

NON-LICENSED PROVIDERS

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

SERVICES THAT DO NOT REQUIRE LICENSURE

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

SUPERVISION OF NON-LICENSED PROVIDER

Services for the supervision of a non-licensed Provider.

SURROGACY

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

TRANSPORTATION AND TRAVEL EXPENSE

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

VI. Under the PART entitled YOUR GENERIC PRESCRIPTION DRUG BENEFITS under the section entitled DRUG UTILIZATION Review the following language has been added as a new section:

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.

VII. Under the section entitled **BINDING ARBITRATION** the second paragraph has changed to read as follows:

This Binding Arbitration provision does not apply to class actions.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE ~~PLAN~~POLICY OR ANY OTHER ISSUES RELATED TO THE ~~PLAN~~POLICY AND CLAIMS OF MEDICAL MALPRACTICE ~~MUST BE RESOLVED BY BINDING ARBITRATION~~, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ~~California Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute including disputes relating to the delivery of services under the policy or any other issues related to the policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."~~ YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

The subsequent language in this part has not changed.

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

Under the PART heading the following language will appear as the fifth paragraph:

Revoking or modifying an authorization.

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

- Your coverage under this policy ends;

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

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

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

IX. Under the part entitled INDEPENDENT MEDICAL REVIEW OF GRIEVANCES under the section entitled "For Denials, Modifications or Delays Based on a Determination that a Service is Experimental or Investigative" the 4th and 5th paragraphs have changed to read as follows:

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

"Acceptable medical and scientific evidence~~support~~" is means the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards,
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act,
- ~~Either of the following reference compendia:-The American Hospital Formulary Service's-Drug Information-, and the American Medical Association Drug Evaluation-, the American Dental Association Accepted Dental Therapeutics ~~and the United States Pharmacopeia Drug Information,~~~~
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
 - The Elsevier Gold Standard's Clinical Pharmacology.
 - The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - The Thomson Micromedex DrugDex.

All subsequent bullets will remain the same.

X. Under the part entitled IMPORTANT TERMS TO KNOW the following terms have been added alphabetically, removed or revised as illustrated below:

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

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

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

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

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

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

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

- One of the following providers but only when the provider is licensed to practice where the [health care service](#) is provided and is rendering a [Covered sService](#) within the scope of that license. The provider must also be providing a [Covered sService](#) for which benefits are specified in this Policy and those benefits would be payable if the services had been provided by a Physician as defined above:

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


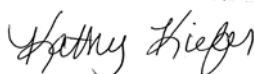
Provider is someone who renders health care services to you, is licensed to practice where the health care service is provided, is rendering a health care service within the scope of that license, and is providing a healthcare service for which benefits are specified under the part entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED BY ANTHEM.

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

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

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

 <p>Leslie A. Margolin Chief Executive Officer Anthem Blue Cross Life and Health Insurance Company</p>	 <p>Kathy Kiefer Secretary Anthem Blue Cross Life and Health Insurance Company</p>
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WELCOME TO TONIKSM
We've got you covered.

Congratulations! By enrolling in your own health insurance, you've made a wise investment in your health and financial future. You can begin to use your plan on the Effective Date printed on your ID card.

Get Plugged In

The hardest part is behind you – but there are still a few very important things about your health coverage you should be aware of. Like knowing how to program your cell phone or setting up your stereo, you have to make sure you know how your plan works in order to get top performance. We want you to get the most out of your coverage, and this booklet will tell you how. So get comfortable and take a few minutes to review the information. It's important that you read it carefully and understand it. It is our contract with you and tells you what benefits you can get and what are the terms, conditions, limitations and exclusions of your coverage. When you're done, you will know:

- How to take advantage of benefits to keep you healthy
- What to do in an emergency
- How to get special care if you need it
- What's not covered

This booklet provides coverage for health, dental and vision. Please read the entire booklet to get a full understanding of your health, dental and vision benefits.


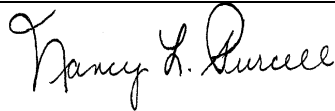
As you read, you'll see certain terms that are capitalized. You can find out the meaning of these words by looking in the back under Important Terms to Know.

Internet and Phone Resources

You can also find fast and easy information on your plan by checking out our website at **tonikhealth.com**. If you don't understand something or you have a question call us at **(866) 333-4820**. Sometimes we record phone calls to make sure that the people you talk to are friendly and helpful.

Taking responsibility for your health really does matter, and we're here to help.

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

 <p>Leslie A. Margolin Chief Executive Officer Anthem Blue Cross Life and Health Insurance Company</p>	 <p>Nancy L. Purcell Secretary Anthem Blue Cross Life and Health Insurance Company</p>
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Note: Coverage is provided by Anthem Blue Cross Life and Health Insurance Company (known as "Anthem Blue Cross Life and Health" "Anthem"), which is an affiliate of Anthem Blue Cross, and Anthem Blue Cross will administer your coverage for Anthem Blue Cross Life and Health.

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.

Individual Tonik \$5,000
DN15 (T775)

03-01-2009

Questions? Visit www.Medicoverage.com or call (800) 930-7956

**Anthem Blue Cross Life and Health Individual Tonik
\$5,000**

A Prudent Buyer Plan

Issued By
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

This booklet is called a Policy. It will tell you how your health plan works, which health services are covered and which services are not covered. It will tell you what your benefits are, when and how you have (and don't have) a right to these benefits. Please read your Policy completely and carefully. If you have special health care needs, carefully read those sections that apply to you.

YOU HAVE THE RIGHT TO LOOK AT THIS POLICY PRIOR TO ENROLLMENT.

You can request a copy of the "Notice of Privacy Practices," which explains your rights. You can get a copy by checking our website at tonikhealth.com or by calling us at (866) 333-4820.

Anthem Blue Cross Life and Health Insurance Company enters into this Policy with you based upon the answers submitted by you, (or if the Policyholder is under the age of 18 years, by the Policyholder's parent or guardian) 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 subject to all the terms, conditions, limitations and exclusions of this Policy.

In this Policy, "we," "us" and "our" mean Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) (Anthem). "You," "your" or "Policyholder" means the eligible Policyholder whose individual enrollment application has been accepted by us.

If you are under the age of 18 years, your parent or legal guardian may not have your rights as the Policyholder, but your parent or legal guardian will be considered the responsible party, and therefore, will be held liable for all financial and/or contractual obligations of this Policy until you are 18 years of age.

Note: This Policy covers the named Policyholder only and does not provide benefits for dependents, such as spouse, domestic partner, newborn, legal ward, and natural and/or adopted child. However, if you have a dependent, he or she may apply for coverage as a policyholder under his or her own separate policy. A completed application must be received by Anthem if you are requesting coverage for a dependent. For dependents under the age of 18 years (including newborns), a parent or guardian must complete the application on behalf of the dependent. **Please be aware that an application for coverage does not guarantee coverage; all applications are subject to medical underwriting.**

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 might need.

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

You should obtain more information before you become a Policyholder or select a network provider. Call your prospective doctor or clinic, or call customer service toll free at (866) 333-4820 to ensure that you can obtain the health care services that you need.

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

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.

If, within two (2) years after the Effective Date of this Policy, we discover any material facts that were omitted or that you knew, but did not disclose on your application, we may rescind this Policy as of the original Effective Date.

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 this 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.

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.

IMPORTANT!

This is not an annual Policy. The duration of your coverage depends on the method of payment you chose under paragraph 2. under the Section entitled **DURATION OF 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, subject to our right to terminate, cancel or non-renew as described in the Section entitled **HOW YOUR COVERAGE ENDS**. Also, premiums, benefits, terms and conditions may be modified at any time during the Year following thirty (30) days written notice pursuant to the Section entitled **NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY**. Please read the Sections entitled **DURATION OF YOUR POLICY, HOW YOUR COVERAGE ENDS and NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY** carefully and in their 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.

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Questions? Visit www.Medicoverage.com or call (800) 930-7956

PART 1 HOW TO USE YOUR HEALTH PLAN

As a Policyholder, you have a wide range of medical benefits, so it's important that you know how your plan works in order to use them to your best advantage.

Throughout this Policy, if you see a word or term, which appears with the first letter of each word in capital letters, you can look up its definition in the back of this booklet under IMPORTANT TERMS TO KNOW. Also, some terms are defined within a benefit description or part.

USING YOUR ID CARD

Your Anthem identification (ID) card not only identifies you, but it also lists important phone numbers. Carry your ID card with you at all times and present it whenever you are having medical care or services. You can find your Effective Date of coverage on your ID card. This is the date your health care benefits start with us. You are the only person who can get health care services under this Policy. If you let someone else use your ID card, your coverage could be terminated.

CHOOSING DOCTORS AND HOSPITALS

Please read the following information because the type of provider you choose will affect your payment responsibility.

Benefits are available in-network

This Anthem Preferred Provider Organization (PPO) Plan gives you access to care through a network of Hospitals, Physicians and other providers. These in-network providers are called Participating Providers. They contract with us to provide services to you at pre-negotiated discounted fees (called the Negotiated Fee Rate). Covered Expense for Participating Providers is based on this 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. Using Participating Providers assures maximum savings for you. In addition, Participating Providers will file your claims with us. For a directory of Participating Providers or more information, visit our website or call us toll free. **Note:** Even if a Hospital is a Participating Provider, some Physicians and other providers of health care at the Hospital may not be Participating Providers. If you need to have services in a Hospital, whenever possible you should be sure to request that the Physicians (such as, anesthesiologists, pathologists or radiologists) who provide treatment to you are Participating Providers.

Benefits are still available out-of-network

You can still go to out-of-network providers (called Non-Participating Providers) and receive benefits for Covered Services. However, Non-Participating Providers do not have a Prudent Buyer Participating Provider Agreement with us, and you will pay a much greater share of the cost when you receive services from them. They may charge you whatever they like, but we will pay benefits based only on the amount we say in this Policy that we will allow for Non-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, in addition to any other Copayments, Coinsurance and Deductible. Please read the benefit sections carefully to determine those differences.

Please note, no benefits are available for care furnished in Non-Contracting Hospitals, except for Medical Emergencies. Non-Contracting Hospitals have neither a standard contract nor a Prudent Buyer Participating Hospital Agreement with Anthem.

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

MAKING AN APPOINTMENT WITH THE DOCTOR

Call the doctor's office for an appointment and tell them you are insured with us. Have your identification (ID) card with you when you call because you may be asked for the ID number on the card. If you're going to be late or you can't go to your appointment, call your doctor's office as soon as possible. This will help your doctor reduce the time everyone waits in the waiting room.

GETTING A SECOND MEDICAL OPINION

If you have a question about your condition, or about a plan of treatment that 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 better benefits are provided when you choose a Participating Provider. You may ask your Physician to refer you to a Participating Provider to receive a second opinion.

HOW TO SUBMIT A CLAIM

Participating Providers will submit your claims with us. However, if you go to a Non-Participating Provider either you or your provider of service must claim benefits by sending Anthem properly completed claim forms itemizing the services or supplies received, and the charges. Claim forms that you submit 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 the Policyholder's legal capacity. Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available on our website at tonikhealth.com. You can also request claim forms by telephone at (866) 333-4820 or by writing to us. Use the following address to request claim forms or to send your completed claim forms:

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

Please remember that we will not pay for services or supplies for the treatment of a Pre-existing Condition during a period of six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-two (62) days.

For information about how your plan works, including your Deductible, Copayments/Coinsurance, out-of-pocket maximum and lifetime medical benefit maximum provided under this Policy, please see the PARTS called HOW YOUR PLAN WORKS WHEN YOU NEED CARE and BENEFITS SUMMARY.

PART 2 WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE

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.

Only the named Policyholder is eligible for benefits under this Policy. Other persons, including, but not limited to, the Policyholder's dependents, such as spouse, domestic partner, newborn, legal ward, and natural and/or adopted child, **are not** eligible for coverage under this Policy.

YOUR EFFECTIVE DATE

The Effective Date of your coverage is printed on your Anthem identification (ID) card which is issued together with this Policy and is a part of this Policy.

TRANSFERRING TO ANOTHER INDIVIDUAL PLAN

If you have been covered under this individual plan for at least 18 months, you 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 may need to pass medical underwriting requirements. For further information, please contact customer service toll free at 1-800-333-0912.

PREMIUMS

Premiums are the monthly charges the Policyholder must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the Policyholder's age and the specific regional area in which the Policyholder resides. If the Policyholder changes residence, he or she may be subject to a change in premiums, without prior written notice from Anthem. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the Policyholder 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 Policyholder for the difference in premium from the date the address changed. Anthem will recalculate your premium based upon the age of the Policyholder on your Policy Anniversary Date and your premium will be automatically adjusted to the new rate prior to any other premium change, Anthem will send out written notification 30 days in advance of such change.

There are several billing options available:

- Monthly premium payments are an option if you pay with an automatic checking account deduction or credit card. If you do not select an automated billing method, you will receive a paper bill in the mail every 2 months.
- Premium payments can be made over the phone from your checking account if you use "check by phone" or you can use your credit card.

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

You will be responsible for an additional \$25 charge for any check or debit 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 an automated billing program, you must give us thirty (30) days advance written notice to:

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

If we do not receive your 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. To do this, just call us at (866) 333-4820.

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.

This Policy will terminate 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, if necessary we have the right to deduct the unpaid premiums from the payments for covered benefits.

DURATION OF YOUR POLICY

1. 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.
2. 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.
3. 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 the section entitled HOW YOUR COVERAGE ENDS; or (2) Anthem has modified the Policy pursuant to the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY below. In the case of a modification under the section entitled NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY, the Policy will renew for the term specified in paragraph 2. above under the modified terms and conditions.

HOW YOUR COVERAGE ENDS

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 mailing you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Policy shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem issues the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, we will deduct the premiums due for coverage continued during the grace period from any benefits we pay. The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed. See the section REINSTATEMENT in the PART called IMPORTANT INFORMATION ABOUT YOUR PLAN for the 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.
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 enrolled under any other Anthem Blue Cross and/or Anthem non-group Policy.

NOTICE TO CANCEL OR CEASE COVERAGE AND OUR RIGHT TO MODIFY YOUR POLICY

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 the section HOW YOUR COVERAGE ENDS in 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 HOW YOUR COVERAGE ENDS, Anthem has the right upon renewal, or at any time during the duration of your Policy to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that Anthem gives you thirty (30) days written notice of such modifications or changes. Such modifications or changes may alter any term or benefit of this Policy, including without limitation, premiums, covered benefits, Deductibles, Copayments or Coinsurance. Anthem can modify or change the terms and conditions of your Policy at any time during the Year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.

In addition to the thirty (30) days written notice provision set forth above, Anthem's right to modify this Policy under the paragraph above is subject to the following conditions:

- a. We will not cancel or modify this Policy under this paragraph 3. on an individual basis but only for all covered persons enrolled in the same class that have the same coverage as you, except:

- (i) if we discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by you.
 - (ii) if we find out about any fraud or deception in the use of the benefits of this Policy by you or anyone else if you know about it.
 - b. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in paragraph a. above) on or after the 30th day following the date of the above notice.
4. If, on the date we cancel your coverage on written notice (except for the reasons described in this section under 1. a. and b., 3. or 4.), you are suffering from either an injury sustained or an illness arising while your coverage under this Policy was in effect, benefits will continue, but limited by and subject to all of the following:
- a. These continued benefits cover only treatment of an injury sustained or an illness arising while your coverage under this Policy was in effect. When we refer to an injury sustained while your coverage under this Policy was in effect, we mean that the incident or accident directly causing the injury must have occurred while your coverage under this Policy was in effect. When we refer to an illness arising while your coverage under this Policy was in effect, we mean that either the illness was first diagnosed while your coverage under this Policy was in effect or your illness first manifested itself by signs or symptoms by which a Physician could have diagnosed the illness while your coverage under this Policy was in effect.
 - b. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of your coverage under this Policy. If you are in a Hospital or Skilled Nursing Facility on the last day of that ninety (90) day period for treatment of a condition covered under these continued benefits, benefits will continue until the first of the following occurs:
 - (i) the date of discharge from the Hospital or Skilled Nursing Facility, or
 - (ii) care or treatment is no longer Medically Necessary.
 - c. All conditions, reductions, limitations and exclusions of this Policy, including any benefit maximums, will apply to these continued benefits. In no event will benefits in excess of any maximum benefits be provided.
5. Any written notice will be officially given by us when it is mailed to your address as it appears on our records.
6. You should address any written notice to us at:

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

PART 3 HOW YOUR PLAN WORKS WHEN YOU NEED CARE

For more information about specific benefits and your payment responsibility, please see the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.

WHEN YOU GO TO THE DOCTOR FOR AN OFFICE VISIT

If you need to see a Physician, you pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year when you go to a Participating Provider.

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

1. History (gathering of information on an illness or injury)
2. Examination
3. 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.

If you use these first four (4) Office Visits in a calendar Year, you will then need to satisfy your Deductible before we will pay for subsequent Office Visits. But, after your Deductible has been satisfied, you don't pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year when you go to a participating provider. For information about your payment responsibility if you use a Non-Participating Provider, see the PART called BENEFITS SUMMARY. Please keep in mind that the first four (4) Office Visits in a calendar Year are combined for Participating and Non-Participating Providers.

IF YOU NEED YOUR EYES CHECKED

If you need to have your eyes checked or receive other vision services and supplies, such as eyeglasses or contact lenses, we'll pay up to a maximum amount of \$50 in each calendar Year. See the vision section for additional benefits.

IF YOU'RE CONSIDERING SURGERY OR OTHER SERVICES

If you're considering surgery or you need other Covered Services, you will have to satisfy your Deductible first before we will provide payment. However, remember that while you're covered under this Policy you can always take advantage of amounts (called the Negotiated Fee Rate) that we have negotiated with our network of Participating Providers.

Other things to keep in mind:

WHAT ARE COPAYMENTS AND COINSURANCE

Copayment is a fixed dollar amount per day or per visit, which you are responsible to pay to a Participating Provider for the Covered Services that are described in this Policy.

Coinsurance is a percentage of Covered Expense that you are responsible to pay for the Covered Services that are described in this Policy.

Copayments and Coinsurance can also be a combination of a fixed dollar amount and a percentage of Covered Expense. See the PART called BENEFITS SUMMARY to determine your Copayment and Coinsurance amounts for Participating and Non-Participating Providers.

Some Copayments/Coinsurance **will not** be applied toward your out-of-pocket maximum and **will continue to be required** even after your out-of-pocket maximum and Deductible have been satisfied. See the section WHAT IS YOUR OUT-OF-POCKET MAXIMUM in this PART for a list of these Copayments/Coinsurance amounts.

WHAT YOU PAY BEFORE YOU MEET YOUR DEDUCTIBLE

For the following Covered Services your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply.

- The first four (4) Office Visits in a calendar Year when you go to a participating provider
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year). See the vision section for additional benefits.
- HealthyCheck Center visits

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

For other Covered Services, we will provide payment after you first satisfy your \$5,000 Deductible in each calendar Year. Until your \$5,000 Deductible has been satisfied, you will pay 100% of the Negotiated Fee Rate for Covered Services that you receive from Participating Providers, and you will pay 100% of all charges for Covered Services that you receive from Non-Participating Providers.

WHAT IS YOUR DEDUCTIBLE

Deductible is the amount that you will pay before we begin to pay for certain Covered Services. However, you can receive benefits for the Covered Services (listed above in bullet points) without paying your Deductible first. Before we provide payment for other Covered Services, you will need to first satisfy your **\$5,000** Deductible in each calendar Year. Only Covered Expense will apply toward your Deductible. Covered Expense is explained in the section called HOW COVERED EXPENSE IS DETERMINED. This Deductible is not prorated for a partial calendar Year.

Once your \$5,000 Deductible has been satisfied in a calendar Year, no further Deductible will be required for the remainder of that calendar Year. In addition, for the remainder of that calendar Year:

- you will not have any Copayment or Coinsurance responsibility for Covered Services that you receive from Participating Providers, except as explained in the PART called BENEFITS SUMMARY;
- you will continue to pay Copayments/Coinsurance for Covered Services that you receive from Non-Participating Providers as explained in the PART called BENEFITS SUMMARY; and
- you will continue to be required to pay amounts described in the section WHAT IS YOUR OUT-OF-POCKET MAXIMUM.

A claim must be submitted in order for us to record your eligible Deductible expense. We will record your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. If you submit a claim for services which have a maximum payment limit (for example, Physical and/or Occupational Therapy and Chiropractic Care performed by a Non-Participating Physician, or Mental or Nervous Disorders and Substance Abuse, not including the treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child) and your Deductible has not been satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible.

Amounts that are applied to your calendar Year Deductible for Covered Services that you receive from Non-Participating Providers **will** apply toward your out-of-pocket maximum for Non-Participating Providers.

When you go to a participating provider, amounts paid for the first four (4) Office Visits in a calendar Year and HealthyCheck Center visits will not be applied to your Deductible. Benefits under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS are not subject to this calendar Year Deductible.

WHAT IS YOUR OUT-OF-POCKET MAXIMUM

Out-of-pocket maximum is the maximum amount that you pay in a calendar Year. After you pay the out-of-pocket maximum, you do not need to pay Coinsurance for Covered Services for the remainder of that calendar Year. However, there are a few exceptions, which are explained in the “Exception” section below. Only Covered Expense will be applied to your out-of-pocket maximum for Covered Services. Covered Expense is explained in the section called HOW COVERED EXPENSE IS DETERMINED located at the end of this PART.

For **Participating Providers**, your Deductible is the out-of-pocket maximum amount. Once you have satisfied your **\$5,000** Deductible in a calendar Year, for the remainder of that calendar Year you will not have any Copayment/Coinsurance responsibility for Covered Services that you receive from Participating Providers, except as explained in the PART called BENEFITS SUMMARY and the “Exception” section below.

For **Non-Participating Providers**, your out-of-pocket maximum is **\$10,000** per calendar Year. Once you have satisfied your out-of-pocket maximum in a calendar Year, no further Copayment or Coinsurance will be required for Non-Participating Providers for Covered Services for the remainder of that calendar Year, except as explained in the “Exception” section below. Amounts applied to your calendar Year Deductible for Covered Services that you receive from Non-Participating Providers will apply towards your calendar Year out-of-pocket maximum.

Exception: For certain Covered Services, which are described below, you will continue to be required to pay Copayments and any applicable charges (for example, charges in excess of what we allow) even after your out-of-pocket maximum and Deductible have been satisfied. Also, amounts you pay for Covered Services, as listed below, will **not** accumulate toward satisfying your out-of-pocket maximum for Non-Participating Providers.

■ For Participating Providers:

- Services listed under the benefit called Mental Health Care and Substance Abuse (other than Severe Mental Illness and Serious Emotional Disturbances of a Child)
- Copayment for not obtaining Preservice Review

■ For Non-Participating Providers:

- Services listed under the benefit called Mental Health Care and Substance Abuse (other than Severe Mental Illness and Serious Emotional Disturbances of a Child)
- Copayment for not obtaining Preservice Review
- Physical Therapy
- Occupational Therapy
- Chiropractic Care
- 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

Copayment amounts paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible and out-of-pocket maximum.

Benefits described in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS are not subject to the Deductible. Generic Prescription Drug Copayments/Coinsurance are not applied to the Deductible or out-of-pocket maximum and will continue to be required even after the Deductible and out-of-pocket maximum have been satisfied.

WHAT IS YOUR LIFETIME MEDICAL BENEFIT MAXIMUM

The combined total for all medical and Prescription Drug benefits paid by Anthem for your expenses is limited to a maximum amount of \$5,000,000 during your lifetime, so long as this Policy remains in effect.

HOW COVERED EXPENSE IS DETERMINED

Covered Expense is the expense you incur for Covered Services up to the maximum amount Anthem will allow for Covered Services rendered by each type of provider (listed below). This is not necessarily the amount a provider ordinarily bills for the 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 on a claim. Also, Covered Expense is used to determine the amount that is applied to your Deductible, out-of-pocket maximum and lifetime maximums. Covered Expense is incurred on the date you receive the service or supply for which the charge is made.

For some Covered Services, Covered Expense will be limited to the maximum amount stated in this Policy. Please review this PART and the PARTS called BENEFITS SUMMARY and WHAT IS COVERED for any per day, visit, calendar Year or lifetime limitations.

When services or supplies are received from a Participating Provider:

The maximum Covered Expense is the lesser of the billed charge or the amount negotiated in advance by Anthem (called the Negotiated Fee Rate).

Since the Participating Provider has agreed to accept the Negotiated Fee Rate as payment in full, you will not be responsible for any amount billed in excess of the Negotiated Fee Rate. However, you are responsible for any applicable Deductible, Copayments or Coinsurance payments required. Also, you are always responsible for services or supplies not covered in this Policy.

When services or supplies are received from a Non-Participating Provider:

The maximum Covered Expense is the lesser of the billed charge or the amount Anthem would allow if the provider were participating (the Negotiated Fee Rate). But for benefits described in the sections SPECIAL CIRCUMSTANCES, FOREIGN COUNTRY PROVIDERS (for a Medical Emergency only) and OTHER ELIGIBLE PROVIDERS in the PART called BENEFITS SUMMARY, Covered Expense is the lesser of the billed charge or the Customary and Reasonable Charge.

Also, Covered Expense will not exceed a Reasonable Charge for (1) any charge for services of a Non-Participating Hospital, and/or (2) for all other covered providers, services and supplies for which Anthem does not enter into Participating Provider agreements.

Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. Since the Non-Participating Provider has not agreed to accept the above-described amounts as payment in full, the amount billed by the Non-Participating Provider may exceed the Covered Expense. You will need to pay that excess amount, in addition to any applicable Deductible, Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered under this Policy.

No benefits are provided for the few Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated under the section SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA in the PART called BENEFITS SUMMARY.

PART 4 BENEFITS SUMMARY

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, including the PART called WHAT IS COVERED, 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.

For the following Covered Services, your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply:

- The first four (4) Office Visits in a calendar Year when you go to a participating provider
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year). See the vision section for additional benefits.
- HealthyCheck Center visits

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

For other Covered Services, we will provide payment after you first satisfy your \$5,000 Deductible in each calendar Year. Until your \$5,000 Deductible has been satisfied, you will pay 100% of the Negotiated Fee Rate for Covered Services that you receive from Participating Providers, and you will pay 100% of all charges for Covered Services that you receive from Non-Participating Providers. Once your \$5,000 Deductible has been satisfied, you will pay the Copayment and/or Coinsurance listed below for Covered Services for the remainder of *that* calendar Year.

Please remember that your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. You will have to pay any part of a provider's bill which is over what we allow in benefits for Non-Participating Providers. **Please see the SPECIAL CIRCUMSTANCES sections under this PART for situations that may reduce your payment responsibility when you use Non-Participating Providers.**

NO BENEFITS ARE PAYABLE FOR CARE FURNISHED IN NON-CONTRACTING HOSPITALS, except as explained in the section called SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA.

Please keep in mind, you also need to read the PARTS called WHAT IS COVERED and WHAT IS NOT COVERED to fully understand what these benefits are. For details about the Deductible, lifetime medical maximum and out-of-pocket maximum, check in the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE. In addition, look at the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS for comprehensive Generic Prescription Drug benefits.

BENEFITS SUMMARY LIST

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)

YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
DEDUCTIBLE	\$5,000 per calendar Year.		
LIFETIME MEDICAL BENEFIT MAXIMUM	\$5,000,000 lifetime maximum benefits paid by Anthem.		
OUT-OF-POCKET MAXIMUM	\$5,000 Deductible per calendar Year, Participating and Non-Participating Providers combined.	\$10,000 per calendar Year.	
OFFICE VISITS	<p>You pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all of the Negotiated Fee Rate.</p> <p>After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.</p>	<p>You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting your annual Deductible.</p>	<p>No Deductible is required for the first four (4) Office Visits when you go to a participating provider.</p> <p>An Office Visit is when you go to the Physician's office and have one or more of ONLY the following three services provided:</p> <ol style="list-style-type: none"> 1. History (gathering of information on an illness or injury) 2. Examination 3. Medical Decision Making (the Physician's actual diagnosis and treatment plan) <p>The Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology, and radiology) or any other services performed other than or in addition to any of the three services specifically listed above.</p> <p>When you go to a participating provider, Copayments paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p>

PROFESSIONAL SERVICES	You do not pay any Coinsurance after meeting your annual Deductible.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting you annual Deductible.	This benefit is separate from professional services covered under the Office Visit benefit (see above). Refer to the section PROFESSIONAL SERVICES under the PART called WHAT IS COVERED for a detailed description of Covered Services.
EMERGENCY ROOM	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	
INPATIENT HOSPITAL	You do not pay any Coinsurance.	You pay all charges except \$650 per day.	A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled CENTERS OF MEDICAL EXCELLENCE (CME) FOR TRANSPLANTS AND BARIATRIC SURGERY under the PART called WHAT IS COVERED. Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
OUTPATIENT HOSPITAL AMBULATORY SURGICAL CENTER	You do not pay any Coinsurance.	You pay all charges except \$380 per day.	Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
VISION	You pay all charges except \$50 per calendar Year.		No Deductible is required. Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. For a description of Covered Services, please see the VISION section in the PART called WHAT IS COVERED. For additional benefits, please see the vision section.

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
<p>PREVENTIVE CARE</p> <p>Adult Preventive Services are provided at your Physician's office and not at the HealthyCheck Centers.</p> <p>Adult preventive services include an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, cervical and ovarian cancer screening tests, PSA (Prostatic Specific Antigen) testing, and the Office Visit related to these services.</p>	<p>Office Visits: You pay a \$20 Copayment per Office Visit for the first four (4) Office Visits in a calendar Year.</p> <p>For subsequent Office Visits, you pay all of the Negotiated Fee Rate.</p> <p>After your Deductible has been satisfied, you do not pay any Copayment or Coinsurance for Office Visits for the remainder of that calendar Year.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you do not pay any Coinsurance.</p>	<p>Office Visits: You pay 50% of Covered Expense plus all charges in excess of Covered Expense after meeting your annual Deductible.</p> <p>Professional Services (in the absence of an Office Visit): After your Deductible has been satisfied, you pay 50% of Covered Expense plus all charges in excess of Covered Expense.</p>	<p>No Deductible is required for the first four (4) Office Visits when you go to a participating provider.</p> <p>Copayments paid for the first four (4) Office Visits in a calendar Year will not be applied to the Deductible or out-of-pocket maximum.</p>
<p>HealthyCheck Centers (for the Policyholder age 7 years and above)</p>	<p>You pay \$25 per HealthyCheck Center visit.</p> <p>You pay \$75 per HealthyCheck Center visit for the additional services option (for adults age 18 and above).</p>	<p>This benefit does not apply to Non-Participating Providers.</p>	<p>No Deductible applies. Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your yearly deductible.</p>

<p>PHYSICAL THERAPY OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay all charges except \$25 per visit.</p>	<p>Limited to 24 visits per calendar Year, Participating and Non-Participating Providers combined. Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.</p>
<p>DENTAL INJURY</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay 50% of Covered Expense plus all charges in excess of Covered Expense.</p>	
<p>AMBULANCE</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay 50% of Covered Expense plus all charges in excess of Covered Expense.</p>	
<p>MENTAL HEALTH CARE AND SUBSTANCE ABUSE</p> <ul style="list-style-type: none"> □ Professional Services (inpatient and outpatient Physician services) □ Inpatient Hospital and Day Treatment Program 	<p>You pay all of the Negotiated Fee Rate except \$25 per visit.</p> <p>You pay all of the Negotiated Fee Rate except \$175 per day.</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.</p>	<p>You pay all charges except \$25 per visit.</p> <p>You pay all charges except \$175 per day.</p> <p>Services for Severe Mental Illness and Serious Emotional Disturbances of a Child: Benefits provided the same as for any other medical condition.</p>	<p>Professional Services: Limited to 1 visit per day, 20 visits per calendar Year, Participating and Non-Participating Providers combined.</p> <p>Inpatient Hospital and Day Treatment Program: Benefits are provided up to a maximum Anthem payment of \$5,250 per calendar Year (up to a maximum of 30 days per calendar Year), Participating Providers and Non-Participating Providers combined.</p> <p>Benefit is for treatment of Mental or Nervous Disorders or Substance Abuse and does not include treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child.</p> <p>Payments for Non-Participating Providers will not be applied to your out-of-pocket maximum, and you will continue to be required to pay these amounts even after your out-of-pocket maximum has been satisfied.</p>

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
PROGRAMS TO STOP SMOKING	You pay all charges except a \$50 lifetime reimbursement.		
OTHER ELIGIBLE PROVIDERS <input type="checkbox"/> Blood Bank <input type="checkbox"/> Dentist (D.D.S.) <input type="checkbox"/> Dispensing Optician <input type="checkbox"/> Speech Pathologist <input type="checkbox"/> Speech Therapist <input type="checkbox"/> Audiologist <input type="checkbox"/> Respiratory Therapist	You pay all charges in excess of Covered Expense.		These providers do not enter into participating agreements with us, and they must be licensed according to state and local laws to provide covered medical services. Covered Services received from dispensing optician under this benefit is separate from Covered Services received from a dispensing optician under the "VISION" benefit.
MEDICAL SUPPLIES EQUIPMENT AND FOOTWEAR	You do not pay any Coinsurance.	You pay 50% of Covered Expense plus all charges in excess of Covered Expense.	Footwear is limited to a maximum Anthem payment of \$400 per calendar Year, Participating and Non-Participating Providers combined.
SKILLED NURSING FACILITY	You do not pay any Coinsurance.	You pay all charges except \$150 per day.	Limited to 100 days per calendar Year, Participating and Non-Participating Providers combined. Does not include treatment for Mental or Nervous Disorders and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).
HOME HEALTH CARE	You do not pay any Coinsurance.	You pay all charges except \$75 per visit.	Limited to 60 visits per calendar Year, up to four (4) hours each visit, Participating and Non-Participating Providers combined.

<p>INFUSION THERAPY</p>	<p>You do not pay any Coinsurance.</p>	<p>Administrative and Professional Services: You pay all charges in excess of \$50 per day for all expenses (except Drugs).</p> <p>Drugs: You pay all charges in excess of the Average Wholesale Price (AWP) of the Drug.</p> <p>Combined maximum Anthem payment (for administrative, professional and Drugs) will not exceed \$500 per day.</p>	
<p>HOSPICE</p>	<p>You do not pay any Coinsurance.</p>	<p>You pay 50% of Covered Expense plus all charges in excess of Covered Expense.</p>	<p>Limited to a lifetime maximum Anthem payment of \$10,000, Participating and Non-Participating Providers combined.</p>
<p>FOREIGN COUNTRY PROVIDER</p>	<p>For initial treatment of a Medical Emergency only. You pay all charges in excess of Covered Expense.</p>		<p>You are responsible, at your expense, for obtaining an English language translation of foreign country provider claims and medical records.</p>
<p>SPECIAL CIRCUMSTANCES FOR AUTHORIZED REFERRALS</p>	<p>This benefit does not apply to Participating Providers.</p>	<p>You pay all charges in excess of Covered Expense.</p>	<p>Non-Participating Providers: Physician, Hospital (inpatient or outpatient), Ambulatory Surgical Center</p>

YOUR PAYMENT AFTER DEDUCTIBLE IS MET (unless otherwise noted)			
YOUR MEDICAL BENEFITS	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER	INFORMATION YOU SHOULD KNOW
<p>SPECIAL CIRCUMSTANCES FOR MEDICAL EMERGENCIES WITHIN CALIFORNIA</p>	<p>Benefits are the same as non-Medical Emergency benefits.</p>	<p>Professional Services: You pay all charges in excess of Covered Expense.</p> <p>Emergency Room: You do not pay any Coinsurance.</p> <p>Hospital and Non-Contracting Hospital: You pay all charges in excess of Covered Expense for the first 48 hours. After 48 hours, you pay all charges except \$650 per day.*</p> <p>Ambulatory Surgical Center: You pay all charges in excess of Covered Expense.</p> <p>Ambulance: You pay all charges in excess of Covered Expense.</p>	<p>Hospital and Non-Contracting Hospital: *If you can demonstrate to Anthem that your medical condition reasonably prevented transfer to a Participating facility after the first 48 hours, then your payment will remain at all charges in excess of Covered Expense until your medical condition permits transfer to a Participating facility.</p>

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

□ **Hospital or Ambulatory Surgical Center**

PPO Provider:

You do not pay any Coinsurance.

Traditional Provider:

You pay 50% of the BlueCard provider's Negotiated Price.***

Inpatient Hospital:

You pay all charges **except** \$650 per day.

Outpatient Hospital and/or Ambulatory Surgical Centers:

You pay all charges **except** \$380 per day.

YOUR PAYMENT – NO DEDUCTIBLE REQUIRED			
YOUR GENERIC PRESCRIPTION DRUG BENEFITS	WHEN YOU GO TO A PARTICIPATING PHARMACY	WHEN YOU GO TO A NON-PARTICIPATING PHARMACY	INFORMATION YOU SHOULD KNOW
<p>RETAIL PHARMACIES</p> <ul style="list-style-type: none"> □ Generic Drugs □ Self-Administered Injectable Drugs <p>WHEN YOU ORDER BY MAIL</p> <ul style="list-style-type: none"> □ Generic Drugs 	<p>You pay a \$15 Copayment for each Prescription and/or refill for each 30-day supply.</p> <p>You pay 30% of the Negotiated Fee (except for insulin) for Drugs listed on the Blue Cross Generic Prescription Drug Formulary.</p> <p>You pay a \$15 Copayment for each Prescription and/or refill for each 30-day supply.</p> <p>You pay a \$30 Copayment for each Prescription and/or refill up to a maximum 60-day supply.</p>	<p>The rate of reimbursement is 50% of the Drug Limited Fee Schedule amount, less the Copayment/Coinsurance as stated for Participating Pharmacies.</p> <p>Not Applicable.</p>	<p>Your Prescription Drug benefit (including mail service Prescription Drugs) covers only Generic Prescription Drugs listed on the Blue Cross Generic Prescription Drug Formulary.</p> <p>Outpatient Generic Prescription Drug benefits are separate from your medical benefits.</p> <p>This is a just a brief description of your Prescription Drug benefits; for detailed information, including exclusions, limitations and conditions of coverage, please see the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.</p>

PART 5 WHAT IS COVERED

COVERED SERVICES

Described below are the types of services covered under this Policy for the treatment of a covered illness, injury or condition.

Remember, for the following Covered Services your Deductible is waived, which means you can get these services without paying your Deductible first, but you will be responsible for any Copayments and Coinsurance that apply:

- The first four (4) Office Visits in a calendar Year when you go to a participating provider
- Vision benefits (up to the maximum Anthem payment of \$50 in a calendar Year). See the vision section for additional benefits.
- HealthyCheck Center visit

Generic Prescription Drugs, as explained in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS, are not subject to the Deductible.

All other Covered Services are subject to the calendar Year Deductible including any limited benefits. The medical Deductible is described in the DEDUCTIBLE section in the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE.

Before you review this list of Covered Services, take a moment to review the definitions of Negotiated Fee Rate, Covered Expense 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 called UTILIZATION MANAGEMENT AND PRESERVICE REVIEW describes in detail what services require Preservice Review and how to obtain Preservice Review.

PROFESSIONAL SERVICES

- Services of a Physician, including surgeons and specialists.
- Services of an anesthesiologist or anesthesiologist.
- Outpatient diagnostic radiology and laboratory services.
 - Note:** The following procedures require Preservice Review:
 - Computerized Tomography (CT) scan
 - Positron Emission Tomography (PET) scan
 - Magnetic Resonance Imaging (MRI) scan
 - Magnetic Resonance Spectroscopy (MRS) scan
 - Nuclear Cardiology (NC) scan.
- FDA-approved cancer screenings including an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, ovarian and cervical cancer screening tests, including the human papilloma virus (HPV) test for cervical cancer, prostate specific antigen (PSA) testing, and the Office Visit related to these services. These services are provided at your Physician's office and not at the HealthyCheck centers.
- Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Prosthetic devices related to a laryngectomy.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Prosthetic devices to achieve symmetry after mastectomy.
- The first pair of contact lenses or eyeglasses, when required as a result of covered eye surgery.

- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- Injectable contraceptives, except Norplant, when administered in a Physician's office.
- FDA approved medications that may be dispensed only by a Physician.
- Hepatitis B and Varicella Zoster (chicken pox) vaccines and other appropriate vaccinations as recommended by the American Academy of Pediatrics for the Policyholder age 7 through 18 and the Office Visit associated with administering that vaccination when ordered by your Physician.
- Reconstructive Surgery, which 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.

HOSPITAL

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

- A Hospital room with two or more beds. If a private room is used, we will allow only up to the prevailing two-bed room rate.
- Services in special care units.
- Operating 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 you are hospitalized, including take home Drugs billed on your inpatient Hospital bill and dispensed by the Hospital's Pharmacy at the time of your 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.

LIMITED PROFESSIONAL SERVICES

- Outpatient speech therapy when following surgery, injury or non-congenital organic disease.
Note: Limited to 50 visits per calendar Year. We will not pay for more than 50 visits maximum per calendar Year unless authorized by Anthem in advance of the services being rendered. If Anthem determines that an additional period of speech therapy is both Medically Necessary and likely to result in a significant improvement to the Policyholder's condition during that period of additional care, Anthem will authorize a specific number of additional visits.
- Physical Therapy, Occupational Therapy and/or Chiropractic Care visits, when rendered by a Physician are limited to a maximum of 24 visits per calendar Year combined for Participating and Non-Participating Providers.
Note: If Anthem determines that an additional period of Physical Therapy, Occupational Therapy and/or Chiropractic Care is both Medically Necessary and likely to result in a significant improvement to your condition during that period of additional care, Anthem will authorize a specific number of additional visits.
- Footwear services in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness. Limited to a maximum Anthem payment of \$400 per calendar Year combined for Participating and Non-Participating Providers.

VISION

We will pay up to a maximum of \$50 per calendar Year for vision services, such as a routine eye exam, eyeglasses or contact lenses, for Participating Providers and Non-Participating Providers combined. Covered Services received under this benefit are separate from Covered Services received under any other benefit described in this Policy. See the vision section for additional benefits.

PREVENTIVE CARE

Taking advantage of preventive care is important to help keep you healthy. The following preventive care services are available:

Adult Preventive Services

The following services are provided at your Physician's office and not at the HealthyCheck Centers:

- Annual pap exam
- Breast exams
- Mammogram testing and appropriate screening for breast cancer
- Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Cervical and ovarian cancer screening tests
- Prostatic Specific Antigen (PSA) testing (for men)

See the PART called BENEFITS SUMMARY under the OFFICE VISITS section for further information about Covered Services and your payment responsibility.

HealthyCheck Centers

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/healthycheck 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 or \$75 Copayment per visit for services performed at a designated HealthyCheck Center. No Deductible is required. This Copayment does not apply toward your Deductible. These services are not available to the Policyholder under 7 years.

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 at HealthyCheck Centers:

For the Policyholder age 19 and above

\$25 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

\$75 Premium 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 THERAPY, OCCUPATIONAL THERAPY AND/OR CHIROPRACTIC CARE

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

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

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

These services are limited to a maximum of 24 visits per calendar Year.

DENTAL SERVICES

- 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 Policyholder 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. Benefits are described in the DENTAL INJURY section under the PART called BENEFITS SUMMARY.
- General anesthesia and associated facility charges for dental procedures in a Hospital or surgery center for the Policyholder if:
 - Under seven (7) years of age;
 - Developmentally disabled, regardless of age;
 - Your health is compromised and general anesthesia is Medically Necessary, regardless of age.

AMBULANCE

- Base charge and mileage to transport you to, or from, a Hospital or Skilled Nursing Facility when Medically Necessary.
- Non-reusable supplies.
- Monitoring, electrocardiograms (EKG or ECG), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with the ambulance service. An appropriately licensed person must render the services.
- Payment of benefits for ambulance services will be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid.
- 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 TO BE USED ONLY 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.

MENTAL HEALTH CARE AND SUBSTANCE ABUSE

This benefit is for treatment of Mental or Nervous Disorders and Substance Abuse and does not include the treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child.

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

PROGRAMS TO STOP SMOKING

We will pay up to \$50 during the Policyholder's lifetime toward any smoking cessation program designed to end the Policyholder's dependence on nicotine.

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 Policyholder 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 called WHAT IS NOT COVERED.

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

WIGS

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

SKILLED NURSING FACILITIES

Limited to 100 days per calendar 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 allow only 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.

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 60 visits per calendar 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.

INFUSION THERAPY

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

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

Covered Services include:

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

Infusion Therapy benefits will not be provided for:

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

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

CANCER CLINICAL TRIALS

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

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 Expense 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 the Policyholder, who is a patient, about the disease process and the daily management of diabetic therapy.
- Includes self-management training, education and medical nutrition therapy to enable you 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 this Policy's benefits for professional services rendered by Physicians.

As listed on the Blue Cross Generic Prescription Drug Formulary 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 may be obtained from a retail Pharmacy or through the mail service prescription drug program. See the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

PHENYLKETONURIA (PKU)

Coverage for the testing and treatment of phenylketonuria (PKU) is paid on the same basis as any other medical condition. Coverage for treatment of 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 this Policy. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Coverage for the cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician, nurse practitioner or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments and as Medically Necessary for the treatment of PKU. While formulas and special food products used in the treatment of PKU may be obtained from a Pharmacy, formulas and special food products in this Policy are covered only as medical supplies as described in this PART and in the PART called BENEFITS SUMMARY.

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

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

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

TREATMENT FOR SEVERE MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illness and Serious Emotional Disturbances of a Child will be provided at the same levels of coverage as other medical diagnoses. These services are subject to all other terms, conditions, limitations and exclusions, stated in this Policy including Deductibles and maximum amounts described in the PARTS called HOW YOUR PLAN WORKS WHEN YOU NEED CARE and BENEFITS SUMMARY. See the PART called IMPORTANT TERMS TO KNOW for a definition of Severe Mental Illness and Serious Emotional Disturbances of a Child.

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

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

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a CME facility. Information on CME facilities can be obtained by calling **1-866-333-4820**.

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed by a 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 bariatric surgical procedures and related services are covered only when the bariatric surgical procedures and related services are performed at an Anthem CME. Preservice Review is required.

Bariatric Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Policyholder's home is 50 miles or more from the nearest bariatric CME. All travel expenses must be approved by Anthem in advance.

- Transportation for the Policyholder to and from the CME up to \$130 per trip for a maximum of three (3) trips (one (1) pre-surgical visit, the initial surgery and one (1) follow-up visit).
- Transportation for one companion to and from the CME up to \$130 per trip for a maximum of two (2) trips (the initial surgery and one (1) follow-up visit).
- Hotel accommodations for the Policyholder 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 Policyholder's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at **1-866-333-4820**. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Organ and Tissue Transplants (requires Preservice Review): You or your Physician must obtain Preservice Review for all services related to specified organ and tissue transplants (heart, liver, lung, heart/lung, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). **Preservice Review can be obtained by calling toll free 1-888-613-1130.**

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

The following services are provided to you in connection with a covered organ or tissue transplant, if you are:

- The organ or tissue recipient, or
- The organ or tissue donor.
- If you are the recipient, an organ or tissue donor who does not have coverage provided by Anthem or its affiliates is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
- The Policyholder who needs to store cord blood and the storage is considered Medically Necessary according to the Anthem criteria for cord blood storage at an Anthem designated facility.

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

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

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

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

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

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

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.

Benefits for Hospice services are limited to a lifetime maximum Anthem payment of \$10,000 for Participating and Non-Participating Providers combined.

PART 6 WHAT IS NOT COVERED

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

ACUPUNCTURE AND ACUPRESSURE

COSMETIC SURGERY

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

CUSTODIAL CARE

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

DIAGNOSTIC ADMISSIONS

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

DURABLE MEDICAL EQUIPMENT

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

EDUCATIONAL SERVICES AND NUTRITIONAL COUNSELING

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

EXCESS AMOUNTS

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

EXPERIMENTAL OR INVESTIGATIVE

Medical, surgical and/or other procedures, services, products, drugs or devices (including implants), except as specifically stated under CANCER CLINICAL TRIALS in the PART called WHAT IS COVERED, which are either:

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

FOOD AND/OR DIETARY SUPPLEMENTS

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

GOVERNMENT SERVICES

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

HEARING AIDS

Hearing aids and routine hearing tests.

INFERTILITY SERVICES

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

MATERNITY/PREGNANCY CARE

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

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

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

NON-CONTRACTING HOSPITAL

No benefits are provided for care or treatment furnished in a Non-Contracting Hospital, **except** for a Medical Emergency as defined in the PART called IMPORTANT TERMS TO KNOW. This exclusion applies **only** in California.

NON-DUPLICATION OF MEDICARE

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

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

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

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

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

NOT COVERED BEFORE YOUR EFFECTIVE DATE OR AFTER YOUR COVERAGE ENDS

Services received before your Effective Date or during an inpatient stay that began before your Effective Date. Services received after your coverage ends.

NOT MEDICALLY NECESSARY

Any services or supplies that are:

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

ORTHOPEDIC SHOES

except when joined to braces or shoe inserts.

OTHER DENTAL SERVICES

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

OTHER VISION CARE AND CERTAIN EYE SURGERIES

Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, routine eye refractions, and certain eye surgeries or any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), except as specifically stated under the VISION sections in the PARTS called BENEFITS SUMMARY and WHAT IS COVERED, and as stated in the vision section.

OUTDOOR TREATMENT PROGRAMS

OUTPATIENT DRUGS AND MEDICATIONS NOT FROM A PHARMACY

Any Drugs, medications or other substances dispensed or administered in any outpatient setting, except as specifically stated under the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

OUTPATIENT SPEECH THERAPY

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

PERSONAL COMFORT ITEMS

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

PRE-EXISTING CONDITIONS

No payment will be made for services or supplies for the treatment of a Pre-existing Condition during a period of six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if the length of time between the ending date of your prior coverage and your Effective Date under this Policy did not exceed sixty-two (62) days.

PRIVATE DUTY NURSING

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

ROUTINE PHYSICAL EXAMS

or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as provided during Office Visits as described in the OFFICE VISITS section under the PART called BENEFITS SUMMARY.

SERVICES FOR SOMEONE OTHER THAN THE POLICYHOLDER

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

SERVICES 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 your home or who is related to you by blood, marriage or adoption.

SEX CHANGE

Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to sex change.

TELEPHONE AND FACSIMILE MACHINE CONSULTATIONS

UNLISTED SERVICES

Services not specifically listed in this Policy as Covered Services.

WEIGHT REDUCTION

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

WORKERS' COMPENSATION

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

PART 7 YOUR GENERIC PRESCRIPTION DRUG BENEFITS

We will provide outpatient Generic Prescription Drug benefits as explained in this PART, subject to all other terms, conditions, limitations and exclusions of this Policy. For the meaning of a term, which appears with the first letter of each word in capital letters, look at the PRESCRIPTION DRUG DEFINITIONS section at end of this PART.

Anthem uses a preferred list of Drugs, sometimes called a formulary, to help your doctor make prescribing decisions. Your Prescription Drug benefits cover only Generic Prescription Drugs listed in the Blue Cross Generic Prescription Drug Formulary. This list of Drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes Generic Drugs that are safe and effective in the treatment of disease.

If you have a question regarding whether a Generic Drug is listed on the Blue Cross Generic Prescription Drug Formulary, please call WellPoint NextRx toll free at **(800) 700-2533**. For your convenience, the Blue Cross Generic Prescription Drug Formulary can be accessed online at **tonikhealth.com** or if you would like a copy of the Formulary, please contact us at **(866) 333-4820**.

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the section called Non-Duplication of Medicare under the PART called WHAT IS NOT COVERED.

WHEN YOU GO TO A PARTICIPATING PHARMACY

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

- **Generic Drugs:** \$15 Copayment.
- **Self-Administered Injectable Drugs:** 30% of the Negotiated Fee for Self-Administered Injectable Drugs listed on the Blue Cross Generic Prescription Drug Formulary, except for insulin.

WHEN YOU ORDER BY MAIL

Your mail service prescription drug program is administered by PrecisionRx. Your mail service Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Maintenance Drugs, an ongoing Generic Prescription listed on the Blue Cross Generic Prescription Drug Formulary, can be purchased by mail, requiring the following Copayment to be submitted for each Prescription:

- **Generic Drugs:** You pay a \$15 Copayment for each Prescription and/or refill for each 30-day supply, or a \$30 Copayment for up to a maximum 60-day supply.

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail service prescription drug program including, but not limited to, antibiotics, Drugs that are not listed on the Blue Cross Generic Prescription Drug Formulary, and injectables, including Self-Administered Injectables except insulin. Please check with the PrecisionRx customer service department at **(866) 274-6825** for availability of the Drug or medication.

WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

Questions? Visit www.Medicoverage.com or call (800) 930-7956

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

WellPoint NextRx
Attn: Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Claim forms are available on our website tonikhealth.com or call customer service at (800) 700-2533. Mail the claim form, with the appropriate portion completed and signed by the pharmacist, to Anthem no later than fifteen (15) months after the date of dispensing.

- **The rate of reimbursement by Anthem when your covered Generic Prescription is filled at a Non-Participating Pharmacy** will be 50% of the Drug Limited Fee Schedule amount less the Copayment/Coinsurance as stated for Participating Pharmacies.

CLAIMS AND CUSTOMER SERVICE

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

WellPoint NextRx
Attn: Anthem Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

or call the toll free customer service phone number at (800) 700-2533.

For **mail service prescription drug program** inquiries, please check the website at www.precisionrx.com or write to:

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

or call the toll free customer service phone number at (866) 274-6825.

WHAT IS COVERED

If listed on the Blue Cross Generic Prescription Drug Formulary, the following Generic Prescription Drugs are covered under this PART.

- Outpatient Generic Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin and insulin syringes prescribed and dispensed for use with insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Generic Prescriptions which contain at least one covered Prescription ingredient.
- Oral contraceptive Generic Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA-approved Prescription contraceptive method will be provided.

CONDITIONS OF SERVICE

The Drug or medicine must:

- Be a Generic form of the Prescription and listed on the Blue Cross Generic Prescription Drug Formulary.
- Be prescribed in writing by a Physician and be dispensed within one (1) year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration (FDA).
- Be for the direct care and treatment of your illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy, dispensed by a Physician or ordered by mail through the mail service prescription drug program.
- Not be used while you are an inpatient in any facility.

Note: We will provide Prescription Drug benefits up to a 30-day supply for each 30-day period (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 60-day supply).

DRUG UTILIZATION REVIEW

Your Prescription Drug benefits include utilization review of Generic Prescription Drug usage for your health and safety. Certain Generic Drugs may require prior authorization. A Participating Pharmacist can help arrange to dispense an emergency amount of a covered Generic Prescription Drug. 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.

WHAT IS NOT COVERED UNDER YOUR PRESCRIPTION DRUG BENEFITS

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

- Prescription Drugs that are not listed on the Blue Cross Generic Prescription Drug Formulary.
- Brand Name Drugs, except as listed on the Blue Cross Generic Prescription Drug Formulary.
- Drugs or medications which may be obtained without a Physician's Prescription, except insulin and Niacin for cholesterol lowering.
- All Prescription and non-Prescription herbs, botanicals and nutritional supplements which have not been approved by the Food and Drug Administration (FDA) to diagnose, treat, cure or prevent a disease.
- Non-medicinal substances or items **including** pharmaceuticals to aid smoking cessation (e.g., Nicorette) or any Prescription product containing nicotine. However, please see available benefits described in the PROGRAMS TO STOP SMOKING section under the PART called BENEFITS SUMMARY.
- 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.
- Drugs taken while you are in a Hospital, Skilled Nursing Facility, rest home, sanatorium, convalescent Hospital or similar facility.
- Any expense incurred in excess of the Anthem Negotiated Fee at a Participating Pharmacy.
- Any expense incurred in excess of billed charges or the Average Wholesale Price, whichever is less, at a Non-Participating Pharmacy.
- Any drug labeled "Caution, limited by federal law to investigational use" or non-FDA approved investigational drugs. Any drug or medication prescribed for experimental indications, for example, progesterone suppositories.

- Syringes and/or needles except those dispensed for use with insulin.
- Durable medical equipment, devices, appliances, and supplies except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agents, biological sera, blood, blood products or blood plasma. Oxygen.
- Professional charges in connection with administering, injecting or dispensing Drugs. Infusion medications.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities, doctors' offices and home IV therapy.
- Drugs used for cosmetic purposes, for example, Retin-A for wrinkles and Rogaine for hair growth.
- Drugs and medications used for pregnancy, maternity care or abortion. However, oral contraceptives are covered as specifically stated in the section called 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 the United States.
- Allergy desensitization products, allergy serum.
- All Infusion Therapy is excluded under this Policy except where specifically stated under the PARTS called BENEFITS SUMMARY and WHAT IS COVERED.
- A Prescription dispensed in excess of a 30-day supply (unless ordered by mail through the mail service prescription drug program, in which case the limit is a 60-day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.

PRESCRIPTION DRUG DEFINITIONS

Average Wholesale Price (AWP) is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.

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

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

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 (Blue Cross Generic Prescription Drug Formulary) is a list of Drugs which Anthem has determined to be safe and cost-effective based on available medical literature. This Formulary is used by Blue Cross of California and its affiliate, Anthem Blue Cross Life and Health Insurance Company.

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

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

Negotiated Fees are the fees that Anthem has negotiated with the Participating Pharmacies under Participating Pharmacy agreements for covered Prescriptions. Participating Pharmacies have agreed to charge you no more than the Negotiated Fees for covered Generic Prescriptions.

Non-Participating Pharmacy is a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy. Please see the section called WHEN YOU GO TO A NON-PARTICIPATING PHARMACY for information on the percentage payable at a Non-Participating Pharmacy.

Participating Pharmacy is a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. To identify a Participating Pharmacy, call your local Pharmacy directly or call WellPoint NextRx toll free at (800) 700-2533. Some Participating Pharmacies display an Anthem "Rx" decal so that you can easily identify them.

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

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

PART 8 WHEN YOU TRAVEL OUTSIDE CALIFORNIA

If you plan to travel outside California, it might be a good idea to know your medical and Prescription Drug benefits in advance. The information in this PART describes how the BlueCard Program works and the types of providers you may encounter outside California. If you want to know about your payment responsibility for Covered Services that you receive outside California, look at the SPECIAL CIRCUMSTANCES and BlueCard Program sections in the PART called BENEFITS SUMMARY. Also, your Generic Prescription Drug benefits are described in the PART called YOUR GENERIC PRESCRIPTION DRUG BENEFITS.

BLUECARD PROGRAM FOR MEDICAL SERVICES RECEIVED OUTSIDE CALIFORNIA

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows you 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 (866) 333-4820.

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

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

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

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

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

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

BLUECARD PROVIDER TYPES

PPO Providers

These are primarily Hospitals and Physicians who participate in a BlueCard PPO network and have agreed to provide you 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 you 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 visit the BlueCard website address: www.bcbs.com or call **(800) 810-BLUE (2583)**.

WHEN YOU TRAVEL OUTSIDE THE UNITED STATES

When you are traveling outside the United States, coverage is provided in Medical Emergencies only. Please, call **(800) 810-BLUE (2583)** to inquire about providers that may participate in the BlueCard Worldwide Program.

PART 9 IMPORTANT INFORMATION ABOUT YOUR PLAN

BENEFITS NOT TRANSFERABLE

You are the only person 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 OF THIS POLICY

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 THIS POLICY

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

CONTINUATION OF CARE AFTER TERMINATION OF A PROVIDER

Subject to the terms and conditions set forth below, Anthem will pay benefits to you 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.

- You 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 you 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 you 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 (866) 333-4820 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under this 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, you 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 called INDEPENDENT MEDICAL REVIEW OF GRIEVANCES.

CONTRACTING ENTITY

You hereby expressly acknowledge that you understand that this Policy constitutes a contract solely between you and Anthem, which is an independent corporation operating under a license from the Blue Cross Association, an association of independent Blue Cross Plans, permitting Anthem to use the Blue Cross Service Mark in the state of California, and in doing so, Anthem is not contracting as the agent of the Blue Cross 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 to you for any of Anthem's obligations 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 Policy.

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 REQUIREMENTS

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.

PAYMENT TO PROVIDERS (AND PROVIDER REIMBURSEMENT)

Covered Expense 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

receive services from a Non-Participating Provider or Non-Contracting Hospital, payment may be made directly to you and you will be responsible for payment to that provider. Any assignment of benefits, even if assignment includes the 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. 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 the Policyholder 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 you replace any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the Deductible, out-of-pocket maximum or any benefit maximums of that prior Policy will be applied toward the Deductible, out-of-pocket maximum 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 us toll free at (866) 333-4820 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.

REINSTATEMENT OF COVERAGE FOR MEMBERS OF THE MILITARY

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

RELATIONSHIP OF PARTIES

We are not responsible for any claim for damages or injuries suffered by you 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, you will not be required to pay any Participating Provider for amounts owed to that provider by Anthem (not including Copayments, 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. You 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.

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 called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE. Under this Policy, an expense is incurred on the date you receive 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 called WHAT YOU SHOULD KNOW ABOUT YOUR COVERAGE.
- The benefit to which you may be entitled will depend on the terms of coverage as set out in the Policy in effect on the date you receive the service or supply.

TIME LIMIT ON CERTAIN DEFENSES

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

TIME OF PAYMENT OF CLAIM

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

WORKERS' COMPENSATION INSURANCE

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

PART 10 IF YOU HAVE A COMPLAINT

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 us first toll free at (866) 333-4820 or 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 us toll free at (866) 333-4820 or 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 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 Affairs Bureau
300 South Spring St., South Tower
Los Angeles, CA 90013

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

BINDING ARBITRATION

This Binding Arbitration provision does not apply to class actions.

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

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

Please send all binding arbitration demands in writing to:

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

PART 11 COORDINATION OF BENEFITS AND NON-DUPLICATION OF ANTHEM BENEFITS

There is no coordination of benefits between individual policies.

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

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

PART 12 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. Whenever Preservice Review has not been performed you will be required to pay a \$250 Copayment. **This Copayment is in addition to any other Copayment required by this Policy and will not apply toward satisfying your calendar Year Deductible or out-of pocket maximum. This Copayment is not required in Medical Emergencies.**

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

Preservice Review is required for, but not limited to:

- All elective, urgent or emergent inpatient Hospital admissions (except for mastectomy surgery, including the length of Hospital stays associated with mastectomy).
- Facility Based Treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child and Mental or Nervous Disorders or Substance Abuse.
- 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 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 1-866-333-4820.

PART 13 SUBSTITUTION OF BENEFITS

In order for you 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 suggestions only. Any decision regarding treatment belongs to you and your 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 to you, 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. Also, it does not prevent Anthem from strictly applying the express benefits, limitations and exclusions of the Policy at any other time.

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

- You require 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 you would otherwise receive under the Policy, and
- You or your guardian and your Physician agree, in writing, with Anthem's recommended substitution of benefits with the specific terms and conditions under which the alternative benefits are to be provided.

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

PART 14 INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If you have had any Covered Service denied, modified or delayed or have had coverage denied because proposed treatment is determined by us to be investigational or experimental, or not Medically Necessary, you may ask for review of that denial, modification or delay by an external, independent medical review organization.

To request a review, please call (866) 333-4820 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

You 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 you, who has certified in writing and provided the supporting evidence, that it is more likely to be beneficial than standard treatment.

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

“Acceptable scientific support” is the following sources:

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

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

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

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

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

AND

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

General

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

Within three (3) business days of our receipt from the Department of Insurance of your request 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 you or your 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 (866) 333-4820.

PART 15 IMPORTANT TERMS TO KNOW

Listed below are the definitions of important terms used in this Policy, which appear with the first letter of each word in capital letters. When you see these capitalized words, you should refer to these definitions, which are listed in alphabetical order. Please note some terms may be defined within a specific benefit description or part.

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

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

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

Authorized Referral occurs when you, because of your medical needs, require the services of a specialist who is a Non-Participating Physician or require 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 you live, and
- you are referred to the Non-Participating Hospital or Non-Participating Physician by a Participating Physician, and
- the referral has been authorized by Anthem before services are rendered.

BlueCard Program allows you 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 as stated in the PARTS called BENEFITS SUMMARY and 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 you. 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 (866) 333-4820 which is the telephone number printed on the back of your identification card, and a list of Contracting Hospitals will be sent to you on request.

Copayment is the amount due and payable by you 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.

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

Covered Expense is the expense you incur for Covered Services up to the maximum amount Anthem will allow for Covered Services rendered by each type of provider (listed below). This is not necessarily the amount a provider ordinarily bills for the 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 on a claim. Covered Expense is also used to determine the amount that is applied to your Deductible, out-of-pocket maximum and lifetime maximums. Covered Expense is incurred on the date you receive the service or supply for which the charge is made.

For some Covered Services, Covered Expense will be limited to the maximum amount stated in this Policy. Please review the PARTS called HOW YOUR PLAN WORKS WHEN YOU NEED CARE, BENEFITS SUMMARY and WHAT IS COVERED for any per day, visit, calendar Year or lifetime limitations.

When services or supplies are received from a Participating Provider:

The maximum Covered Expense is the lesser of the billed charge or the amount negotiated in advance by Anthem (called the Negotiated Fee Rate). Since the Participating Provider has agreed to accept the Negotiated Fee Rate as payment in full, you will not be responsible for any amount billed in excess of the Negotiated Fee Rate. However, you are responsible for any applicable Deductible, Copayments or Coinsurance payments required. Also, you are always responsible for services or supplies not covered in this Policy.

When services or supplies are received from a Non-Participating Provider:

The maximum Covered Expense is the lesser of the billed charge or the amount Anthem would allow if the provider were participating (the Negotiated Fee Rate). But for benefits described in the sections SPECIAL CIRCUMSTANCES, FOREIGN COUNTRY PROVIDERS (for a Medical Emergency only) and OTHER ELIGIBLE PROVIDERS in the PART called BENEFITS SUMMARY, Covered Expense is the lesser of the billed charge or the Customary and Reasonable Charge.

Also, Covered Expense will not exceed a Reasonable Charge for (1) any charge for services of a Non-Participating Hospital, and/or (2) for all other covered providers, services and supplies for which Anthem does not enter into Participating Provider agreements.

Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. Since the Non-Participating Provider has not agreed to accept the above described amounts as payment in full, the amount billed by the Non-Participating Provider may exceed the Covered Expense. You will need to pay that excess amount, in addition to any applicable Deductible, Copayments or Coinsurance payment required. You are always responsible for services or supplies not covered under this Policy.

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

Creditable Coverage

1. Any individual or group policy, contract or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental vision coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical Hospital, and surgical care.
5. 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701 (c) (1) (I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
10. A health benefit plan under 22 U.S.C.A. 2504 (e) of the Peace Corps Act.
11. Any other Creditable Coverage as defined by subdivision (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg (c)).

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

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

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

Deductible means the amount of charges you must pay in a calendar Year for any Covered Services before certain benefits are available to you under this Policy. Your Deductible is explained in the PART called HOW YOUR PLAN WORKS WHEN YOU NEED CARE.

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.

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 you 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 your symptoms or condition that requires changes in your 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.

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.

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

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

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

For the purpose of Severe Mental 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 Healthcare Organizations,
- staffed by an organized medical or professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

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

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

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

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

- permanently placing your 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 Policyholder 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 Provider Agreement for Covered Services furnished to you.

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.

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. You will be responsible for any billed charges over the amount allowed under this Policy.

Office Visit is when you go to a Physician's office and have one or more of 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)

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

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 you for Covered Services under this Policy. The exception would be when Preservice Review is not obtained.

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

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

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

Physician means:

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

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

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

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

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 your Effective Date of coverage.

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

Reasonable Charge is a charge that 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 Policyholder resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental disorders or rehabilitative treatment of substance abuse according to state and local laws.

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