Anthem Blue Cross
Health. Join In.

Dear Individual Member,

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

This booklet provides a complete statement of all the benefits available to you. Please read it carefully to be sure you fully understand your benefits, coverage, limitations and exclusions. For your convenience, at the front of this Combined Evidence of Coverage and Disclosure Form is a brief summary of the benefits provided by this booklet. This is only a summary; the Agreement contains the exact terms and conditions of coverage.

Additionally, please keep this booklet in a convenient place so you may refer to it whenever you have a question about your coverage.

If you have any questions regarding your eligibility, claims status or your benefits under this Combined Evidence of Coverage and Disclosure Form, please feel free to contact our customer service department at 1-800-333-0912 or write to Anthem Blue Cross, P.O. Box 9051, Oxnard, California 93031-9051.

Thank you for choosing Anthem Blue Cross.

ANTHEM BLUE CROSS

Leslie A. Margolin
President
Anthem Blue Cross

Kathy Kiefer
Secretary
Anthem Blue Cross

HEALTH PLAN BENEFITS AND COVERAGE MATRIX
CONTRACT CODE: 025T
INDIVIDUAL HIPAA HMO SAVER

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The evidence of coverage and plan contract should be consulted for a detailed description of coverage benefits and limitations.

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

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	**Out of Network**	
Annual Deductible	$1,500 per Member per Year		Deductible applies to covered charges for inpatient and outpatient Hospital facility and Ambulatory Surgical Centers. This Deductible will apply toward satisfying your Yearly Maximum Copayment/ Coinsurance Limit.
Lifetime Maximums	Unlimited		
Professional Services	$10 office visit Copayment, no charge for related services	Not covered	
Outpatient Services	20% of the Negotiated Fee Rate (NFR) after $1,500 Deductible for non-Emergency services	Not covered	
Hospitalization Services	**Inpatient -** 20% of the NFR after $1,500 Deductible for non-Emergency services	Not covered	
Emergency Health Coverage	**Inpatient –** 20% of the NFR after $1,500 Deductible **Outpatient -** $100 Emergency room Copayment plus 20% of the NFR after $1,500 Deductible		Any services provided by a Non-Participating Provider not meeting the CaliforniaCare definition of “Medical Emergency” **will not** be covered. You must notify CaliforniaCare within 48 hours of initial care.
Ambulance Services Other than in a Medical Emergency or Without Authorization	$50 Copayment unless admitted into a Hospital	Not covered	

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out of Network	
Prescription Drug Coverage	**Retail Pharmacies:** **Generic:** $10 Copayment **After $250 Brand Name Deductible:** **Brand:** $30 Copayment **Self-Administered Injectable Drugs (except Insulin):** 30% of the NFR **Mail Order:** **Generic:** $10 Copayment **After $250 Brand Name Deductible:** **Brand:** $30 Copayment	**Retail Pharmacies:** Copayment as stated for Participating Pharmacies **plus** 50% of the Drug Limited Fee Schedule (DLFS) and all charges in excess of the DLFS. **Mail Order:** Not applicable	Refer to your EOC for Prescription Drug exclusions and limitations. Copayment/Coinsurance applies for each 30-day supply; 60-day supply available through Mail Order. Brand Name Prescription Deductible: Two (2) member family maximum $250 Brand Name Prescription Deductible applies to Brand Name Prescription Drugs purchased through the Mail Order Program and at Participating and Non-Participating Pharmacies combined.
Durable Medical Equipment	20% of the NFR	Not covered	Maximum of $2,000 per Member per Year.
Mental Health Services	**Inpatient Services:** Not Covered **Professional Services:** $25 Copayment per visit **Severe Mental Illnesses and Serious Emotional Disturbances of a Child:** Benefits provided the same as for any other medical condition. Amounts you pay for these services will apply toward Your Deductible and Yearly Maximum Copayment/Coinsurance Limit.	**Inpatient Services:** Not covered **Professional Services:** Not covered **Severe Mental Illnesses and Serious Emotional Disturbances of a Child:** **Inpatient Services:** Not Covered **Professional Services:** Not covered	**Professional Services:** Limited to one visit per day, 20 visits per Year. **Benefits for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child are provided as any other medical condition.**
Chemical Dependency Services	20% of the NFR after Deductible	Not covered	Inpatient alcohol or drug abuse detoxification only
Home Health Services	No charge	Not covered	3 two-hour visits per day, 100 visits per Year

Benefit	Your Copayment/Coinsurance		Special Limitations
	In Network	Out of Network	
Pregnancy and Maternity Services	$10 Copayment per office visit, Inpatient/outpatient – 20% of the NFR after Deductible	Not covered	
Physical Therapy, Occupational Therapy and/or Outpatient Speech Therapy	**Outpatient:** $10 Copayment per visit **Inpatient:** No charge	Not covered	Limited to 60 consecutive days following illness or injury; (but additional visits will be covered as authorized by your Medical Group or Anthem if Medically Necessary
Skilled Nursing Facility	No charge	Not covered	100 days of care each Year in a 2-bed room with ancillary services; excludes Mental or Nervous Disorders and Substance Abuse
Chemotherapy & Radiation Therapy	No charge	Not covered	
Acupuncture	Not covered	Not covered	
Yearly Maximum Copayment/Coinsurance Limit	$3,000 per Member per Year or $6,000 per family unit per Year	Not Applicable	Does not include Deductibles applying to Prescription Drugs, and costs for non-Covered Services, services for Mental Health Services and Substance Abuse, except for Severe Mental Illness and Serious Emotional Disturbances of a Child.

HOW TO CONTACT US

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

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

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

For information about…	Contact	Phone Number	Address
Enrollment	Membership	(800) 333-0912	Anthem Blue Cross P.O. Box 9051 Oxnard, CA 93031-9051
Medical Claims and Benefits	Claims	(800) 333-0912	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007
Participating Providers in California	Customer Service	(800) 333-0912	www.anthem.com/ca
Providers outside California	BlueCard Program	(800) 810-BLUE (2583)	www.bcbs.com
Spanish Customer Service	Customer Service	(800) 226-3714	www.nuestrobien.com/
Chinese Customer Service	Customer Service	(888) 951-9633	www.chinese.anthem.com/
Korean Customer Service	Customer Service	(800) 333-0912	www.korean.anthem.com/
Hearing and Speech Impaired Customer Service	Customer Service	TTY (877) 206-4966	
Prior Authorization	Medical Care Management	(800) 274-7767	
Pharmacy (Retail)	WellPoint NextRx	(800) 700-2533	Anthem Blue Cross Prescription Drug Program P.O. Box 4165 Woodland Hills, CA 91365-4165
Pharmacy (Mail Service)	WellPoint NextRx	(866) 274-6825	Anthem Blue Cross Mail Service Prescription Drug Program c/o NextRx P.O. Box 961025 Fort Worth, TX 76161-9863 P.O. Box 746000 Mason, OH 45274 www.wellpointnextrx.com

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INDIVIDUAL HIPAA HMO SAVER

Issued by

ANTHEM BLUE CROSS

INTRODUCTION

For your convenience, at the front of this Agreement and combined Evidence of Coverage and Disclosure Form is a brief summary of the benefits provided by this booklet. The disclosure form is a summary only; the Agreement contains the exact terms and conditions of coverage. Please read the Agreement completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them.

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

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

Participating Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. Participating Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Medical Groups may also receive additional compensation related to the management of services and Referrals. The terms of these arrangements may vary by Medical Group. Hospitals and other health care facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates. For additional information you may contact customer service at 1-800-333-0912 or you may contact your Medical Group.

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

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need:

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

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call customer service toll free at 1-800-333-0912 to ensure that you can obtain the health care services that you need.

If your provider has been terminated and you feel you qualify for continuation of services, you must request that services be continued. This can be done by calling customer service at 1-800-333-0912.

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

The benefits of this Agreement are provided only for those services that Anthem Blue Cross determines are Medically Necessary and a Covered Service. If you have any questions as to whether a service is covered, consult this Agreement or call customer service at 1-800-333-0912. Our customer service representatives can assist you in determining the benefits of your Agreement. Working together as partners in your health care can make your medical experiences less stressful and more cost effective to you.

Our customer service representatives are also available to assist you with the selection of a Participating Medical Group (PMG) or Independent Practice Association (IPA) in your area from our HMO provider directory. An HMO provider directory or information on PMGs and IPAs may be obtained by calling our customer service department toll free at 1-800-333-0912 or by accessing our website at www.anthem.com/ca. Click on Provider Finder and follow the directions to find a Participating Provider in your area. The HMO provider directory is updated quarterly and lists of PMGs and IPAs that are members of the Anthem HMO network. You must select a PMG or IPA located within 30 miles of your home or work location. The directory also has listed the hospitals for each PMG or IPA. Referrals to these hospitals are determined by the PMG or IPA where you are enrolled.

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

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

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

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

IMPORTANT!

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

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

PROGRAMS TO KEEP YOU WELL

Well Baby and Well Child Care

Well Child visits are for children up to and including age 6 years. During these visits, the doctor checks the child's health, hearing, vision, and dental needs. Immunizations (baby shots) are given during these visits. Ask your doctor when you are to bring your child in for the next appointment.

Adult Preventive Services

These services include an annual pap examination, breast exams, mammography testing, appropriate screening for breast cancer, cervical cancer and ovarian cancer, PSA's, and the office visit related to these services. Please review this Agreement to find out more about your coverage.

MEMBER RIGHTS AND RESPONSIBILITIES

We are committed to:

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

Member rights. You have the right to:

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

As a member, you have the responsibility to:

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

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

PART I ELIGIBILITY

Who is Eligible for Coverage

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

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

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

Overage Dependents and Dependents Enrolled as a Full-time Student

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

  OR

- **For Dependents on Medical Leave of Absence from School**
  - The dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate as indicated in this Agreement, whichever comes first.
  - The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first.
  - Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

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

Newborns and Adopted Children

- Newborns of the Subscriber, the Subscriber's enrolled Spouse or enrolled Domestic Partner are automatically enrolled for the first thirty-one (31) days of life. TO CONTINUE COVERAGE FOR A NEWBORN BEYOND THE FIRST THIRTY ONE (31) DAYS OF LIFE, YOU MUST NOTIFY US IN WRITING WITHIN THIRTY ONE (31) DAYS OF BIRTH. THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL SUBSCRIPTION CHARGES DUE EFFECTIVE FROM THE DATE OF BIRTH.

  NEWBORNS OF THE SUBSCRIBER'S DEPENDENT CHILDREN **ARE NOT** COVERED UNDER THIS AGREEMENT.

- A child being adopted by the Subscriber will be automatically enrolled for coverage up to thirty-one (31) days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Subscriber, enrolled Spouse or enrolled Domestic Partner the right to control health care for the adoptive child or, absent this document, the date on which other evidence exists of this right. TO CONTINUE COVERAGE FOR AN ADOPTIVE CHILD, YOU MUST NOTIFY US IN WRITING WITHIN THIRTY ONE (31) DAYS OF THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED. THE SUBSCRIBER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE THE SUBSCRIBER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED

When the Member Becomes Ineligible

The Member becomes ineligible for coverage under this Agreement when:

- The Subscriber does not pay the subscription charges when due, subject to the Grace Period.
- The Spouse is no longer married to the Subscriber.
- The Domestic Partnership has terminated and the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.
- The Family Member fails to meet the eligibility rules listed above.
- The Member fails to cancel any other non-group coverage upon becoming enrolled under this Agreement.
- The member becomes eligible for coverage under a group health plan or Medi-Cal.
- The Member moves to and lives in a place outside of California.

For Misconduct, if the Subscriber or any Family Members:

- Fail to cooperate with prescribed treatment from your Primary Care Physician or Medical Group staff; or
- Engage in threatening, disruptive or abusive behavior or theft in a medical office, Hospital or any other HMO Saver provider location.
- When an act of fraud has been committed.
- When a Member does not make Copayment/Coinsurance payments due under this Agreement after the provider bills the Member or otherwise requests payment of the Copayment/Coinsurance.

Notice of Change in Eligibility

You must notify us of all changes affecting any Member's eligibility under this Agreement within thirty (30) days of the change. You should address any written notice to us at:

Anthem Blue Cross
P.O. Box 9051
Oxnard, CA 93031-9051

PART II YOUR COMPREHENSIVE MEDICAL BENEFITS

BASIC FACTS

As a Member of the HMO Saver, you are entitled to the wide range of medical benefits specified in the PART entitled YOUR BENEFITS - WHAT IS COVERED. These benefits include prenatal, maternity and well baby care, as well as certain preventive services such as physical exams and health education.

WHAT IS HMO SAVER?

Anthem HMO Saver is the Health Maintenance Organization (HMO, for short) from Anthem Blue Cross. It consists of a network of well respected health institutions, Medical Groups and Health Professionals that have contracted with us to provide you with the wide range of medical services and supplies for which you are covered under this Agreement.

YOUR ID CARD

Your key to the HMO Saver is your identification card. Besides identifying you, this card shows the Medical Group to which you belong and gives your Medical Group's address and telephone number. Be sure to keep this card with you at all times and present it whenever you receive care.

CHOOSING A MEDICAL GROUP AND PRIMARY CARE PHYSICIAN

When you, the Subscriber, enrolled, you were asked to choose a personal HMO Saver Medical Group or Independent Practice Association (IPA), hereafter referred to as Medical Group. From this Medical Group, which is staffed by a team of Physicians, nurses and other Health Professionals, you choose your own Primary Care Physician. This Physician will diagnose and treat most illnesses and will coordinate all your health care, referring you to a specialist when necessary. We urge you to develop a close relationship with your Primary Care Physician and to follow his or her advice carefully. Your health is your Physician's primary concern.

YOUR HMO COORDINATOR

If you need help selecting a Primary Care Physician from the staff of your Medical Group, contact the HMO coordinator located at your Medical Group. Your coordinator will also provide you with any information you may need about HMO Saver services and procedures. Feel free to contact your coordinator by phone, in person or by letter.

CHANGING MEDICAL GROUPS

There are two ways you can change Medical Groups:

1. When you move your residence more than 30 minutes travel time or 15 miles from your current Medical Group. If you do move, notify Anthem in writing and request a transfer to another Medical Group that is located within 30 minutes travel time or 15 miles of your new residence. Anthem must be notified within thirty-one (31) days in order to make arrangements.

2. You may otherwise request a change of medical groups upon contacting Anthem. If we receive your request to change medical groups by the 15th of the month, your request will be effective the first day of the following month. If your request is received after the 15th of the month, your request will be effective the first day of the second succeeding month. If you are undergoing a course of treatment or hospitalized, the effective date of your request will be the first of the month following your discharge from the hospital or the date that it is medically appropriate to transfer your care to the new medical group. Anthem must approve your request for the transfer to become effective.

If you move your residence to a location that is outside of your HMO Saver's licensed Service Area, but you continue to reside in the State of California, contact Anthem to enroll in a different type of health care plan.

HOW TO OBTAIN CARE

The procedures you follow to obtain care depend on the type of care you need: primary (general) care, obstetrical/gynecological care, Referral (specialty) care or Emergency care. In reading over these procedures, you will notice one important rule: except for obstetrical and gynecological care, your Primary Care Physician or Medical Group is responsible for authorizing all the care you receive. If you are ever in doubt, contact them or your HMO Coordinator.

PRIMARY (GENERAL) CARE

Your Primary Care Physician is the first person you should consult for medical care. He or she is responsible for providing you with primary medical care, for determining when you need Referral care, and for authorizing Emergency care.

To make an appointment with your Primary Care Physician, call your Medical Group. Call in advance if possible. When you call, IDENTIFY YOURSELF AS AN HMO SAVER MEMBER and give the following information:

- Your name
- Your certificate number and group number from your ID card
- The name of your Primary Care Physician
- A brief explanation of your symptoms

Your Primary Care Physician's office will then schedule an appointment for you or otherwise arrange for appropriate care.

When you come in for your appointment, you will be asked to show your HMO Saver identification card. Since you must have this card to receive your HMO Saver benefits, be sure to have it with you at all times.

If you need to cancel or reschedule an appointment, notify your Medical Group as far in advance as possible. Your call may very well allow the Medical Group to accommodate another person in need of medical attention.

SECOND OPINIONS

Your medical group is responsible for arranging second opinions and specialty care with Providers within or affiliated with your Anthem HMO Medical Group. Working with your medical group supports and improves the coordination and quality of your medical care.

When you have seen a group specialist and want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional within the Anthem HMO network. If there is no appropriately qualified health care professional within the HMO network, we will authorize a second opinion by an appropriately qualified Health Professional, taking into account your ability to travel.

Reasons for requesting a second opinion include but are not limited to:

- Questions about the reasonableness or necessity of recommended surgical procedures
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function or substantial impairment, including but not limited to, a serious chronic condition (Serious Condition)
- The clinical indications are unclear or are complex and confusing
- A diagnosis is in doubt because of conflicting test results
- The first physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time
- You have attempted to follow the treatment plan or you have consulted with the specialist about serious concerns about your diagnosis or plan of care.

To request a second opinion regarding recommendations by your Primary Care Physician, call your Primary Care Physician or your HMO Saver coordinator at your Medical Group.

To request a specialist second opinion outside your Medical Group, please call customer service at 1-800-333-0912. The customer service representative verifies your Anthem Blue Cross membership, obtains preliminary information and gives your request to a Anthem Blue Cross RN Case Manager.

A decision is made within five (5) business days of receipt of the information necessary to make a decision. Decisions on urgent requests are made within a time frame appropriate to your medical condition and no later than the next business day.

When approved, your Case Manager assists you with selection of an Anthem HMO specialist within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled to take place within no more than seventy-two (72) hours. Your Case Manager will work with you and your medical group to make sure the specialist has your medical records before your appointment. Except for your usual Copayment, Anthem Blue Cross covers the specialist's fee.

An approval letter is sent to you and the specialist. The letter includes the services approved and the date of your scheduled appointment. It also includes a toll free number to call your Case Manager if you have questions or need additional assistance. **Approval is for the second opinion only**. It does not include any other services such as lab, x-ray or treatment by the specialist. You and your Primary Care Physician receive a copy of the specialist's report, which includes recommended diagnostic testing or procedures. When you receive the report, you and your Primary Care Physician or group specialist should work together to determine your treatment options and develop a treatment plan. Your Medical Group must authorize all follow-up care.

Only an Anthem Blue Cross Physician Medical Director may decide when Anthem will not cover the fees for a specialist you choose. This may happen when you choose a specialist who is not part of the Anthem HMO network and the same kind of specialist is available within the network. If your request is not approved, your letter will include the names of the specialists that can be approved.

You may appeal a decision not to approve, by following Anthem Blue Cross grievance procedures. Grievance procedures are described in the PART entitled GRIEVANCE PROCEDURES of this Agreement and in your denial letter.

If you have questions or need additional information about this program, please contact your HMO Saver coordinator at your Medical Group or call an Anthem Blue Cross customer service representative at 1-800-333-0912.

OBSTETRICAL AND GYNECOLOGICAL CARE

Obstetrical and gynecological services may be received directly, without obtaining a Referral from your Primary Care Physician, from an obstetrician and gynecologist or family practice Physician who is a member of your Medical Group or who has an arrangement with your Medical Group to provide care for its patients, and who has been identified by your Medical Group as available for providing obstetrical and gynecological care.

SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD

Services for Severe Mental Illnesses and Serious Emotional Disturbances of a Child may be received directly, without obtaining a Referral from your Primary Care Physician. To access care for Severe Mental Illnesses and Serious Emotional Disturbances of a Child, you may:

- Ask your Primary Care Physician to recommend an Anthem Behavioral Health provider.
- Choose a Behavioral Health provider from the HMO Saver directory. If you need a directory, call customer service at 1-800-333-0912 to obtain one.
- Go to Anthem web site at www.anthem.com/ca then click on Provider Finder hotlink.
- Call customer service at 1-800-333-0912 for instruction and help on how to access care.

It is your responsibility to verify that the provider still participates in the Anthem Behavioral Health network by calling customer service at 1-800-333-0912.

Note: A referral is not required from your Primary Care Physician, Members have a right to access Mental Health treatment without a referral if they prefer.

REFERRAL (SPECIALTY) CARE
If you need special care which cannot be provided by your Primary Care Physician at your Medical Group, your Primary Care Physician will arrange to send you to a specialist, within your Medical Group whenever possible, or to a facility outside of your Medical Group.

If you are referred, your Primary Care Physician will give you a completed "Authorization for Referral Services" form which specifies exactly what treatment or services your Physician authorizes. Take this form to the health care provider to whom you have been referred on the appointment date indicated on the Authorization form. That provider will fill in the appropriate parts and will send it back to your Medical Group. If you do not receive the Authorization form, ask for it from your Primary Care Physician or HMO Coordinator.

The reason the Referral provider sends the form back is so that your Medical Group can coordinate the payment for the special services. You should not be billed for Referral services; however, if you mistakenly receive the bill, send it to your HMO coordinator who will see that the appropriate payment is made.

Payment will be made only for the number of visits and the medical care that is specifically authorized by your Primary Care Physician. Before obtaining any other care, be sure to check with your Primary Care Physician to make sure that such additional care will be authorized. You are responsible for paying for services rendered that are not authorized by your Primary Care Physician.

Standing Referrals. If you need continuing care from a specialist, your Primary Care Physician may provide you with a standing referral to a specialist. This referral may be made according to a treatment plan, which will be made if necessary, to decide the course of care, that may limit the number of visits to the specialist or the period of time these visits are authorized. If you have HIV, AIDS, or another life-threatening, degenerative, or disabling condition requiring specialized care for a prolonged period of time, your Primary Care Physician may provide you with a referral to a specialist or a Specialty Care Unit for the purpose of having the specialist coordinate your health care. This referral may also be made according to a treatment plan. For both types of standing referrals, the specialist or Specialty Care Unit to which you are referred will in most cases be part of your Medical Group or will have an arrangement with your Medical Group to provide care for its patients.

EMERGENCY CARE
In Area Emergencies: If you need Emergency treatment it is important that you immediately seek necessary care and/or contact your Medical Group or Primary Care Physician for instructions or so that they may follow up.

If you are unconscious, or if you believe your illness or injury puts you at risk and makes immediate medical care necessary, you should seek medical treatment immediately. Then, you or a member of your family must contact your Primary Care Physician or Medical Group as soon as possible in order to make arrangements for any recommended Follow-up Care with your Primary Care Physician. Continued or Follow-up Care will not be covered unless authorized by your Primary Care Physician or Medical Group. When your Primary Care Physician or Medical Group is contacted, an HMO Saver Physician will either authorize Continued or Follow-up Care, or will take over your care.

If, as a result of the Emergency condition you are admitted into a Hospital through the Emergency room, you or a Member of your family must notify your Primary Care Physician or Medical Group as soon as possible but no later than 48 hours after initial care has been provided, unless extraordinary

circumstances prevent such notification. This notification will allow your Medical Group to manage your care while you are in the Hospital. Failure to notify your Medical Group within the required 48 hours may result in non-payment of your claim.

If you wish to seek urgent medical care for a medical condition which would not be considered an Emergency as defined in the PART entitled DEFINITIONS, your Medical Group may refer you to the Urgent Care Facility affiliated with your Medical Group.

See Emergency Room Copayment/Coinsurance under the PART entitled COPAYMENTS/COINSURANCE for information on when a Copayment/Coinsurance is required.

Out of Area Emergencies: If you need Emergency treatment and you are more than 20 miles from your Primary Care Physician's office or more than 20 miles from your Medical Group, you should seek immediate care. **If, as a result of the Emergency condition you are admitted into a Hospital through the Emergency room, you or a Member of your family must notify Anthem directly as soon as possible but no later than 48 hours after initial care has been provided,** unless extraordinary circumstances prevent such notification. If your condition requires a Hospital stay or long term care, we will monitor your progress and when your condition is stable, facilitate your transfer to your Medical Group's Enrollment Area. Failure to notify Anthem within the required 48 hours may result in non-payment of your claim.

For information on out of state Emergency and urgent care, see the section Out of California Providers in the PART entitled, GENERAL PROVISIONS.

Any services not meeting the HMO Saver definition of Emergency will not be covered.

See Emergency Room Copayment/Coinsurance under the PART entitled COPAYMENTS/COINSURANCE for information on when a Copayment/Coinsurance is required.

Non-Participating Providers. If a Physician or other type of health care provider not connected with the HMO Saver provides treatment because of the need for Emergency care, you will be responsible for any applicable Copayment/Coinsurance.

Non-Covered Services
Coverage will not be provided for:

- Services which do not meet our definition of Emergency (see the PART entitled DEFINITIONS); and
- Continuing or Follow-up Care not provided by your Medical Group, unless you or the provider notifies your Medical Group and requests Authorization.

Extraordinary Circumstances
If Extraordinary Circumstances are present during an Emergency, you may be unable to notify us within the stated time limits, but you will have to notify us as soon as reasonably possible following initial treatment for the Emergency. No benefits will be provided for Continued or Follow-up Care unless you or the provider notifies your Medical Group and requests Authorization.

In determining Extraordinary Circumstances, you may take into account whether or not your illness or injury was severe enough to prevent you from notifying us, and whether Members of your family were available to notify us for you. You may have to prove to us that such Extraordinary Circumstances were present at the time of the Emergency.

The Emergency Care procedures will be strictly enforced. Carefully read the definitions of Emergency and Emergency Service Area in the PART entitled DEFINITIONS.

HOSPITALIZATION

If your Primary Care Physician recommends a non-Emergency (elective) admission to the Hospital, your Medical Group will review the request. If the admission is authorized by the Medical Group, the Member will be directed to an appropriate facility.

If you or a covered HMO Saver Family Member is admitted in an Emergency situation, the Medical Group must be notified. After the Medical Group is notified of the admission and the Member's case is reviewed, the Medical Group may determine that care should be rendered at another facility once the Member's condition is such that transfer is appropriate.

PART III COPAYMENTS/COINSURANCE

COPAYMENT/COINSURANCE FOR CERTAIN SERVICES

While you are not required to make any payment for most supplies and services provided under this Agreement, you are required to pay a Copayment/Coinsurance amount for certain services. These amounts are specified in the COPAYMENT/COINSURANCE LIST.

EMERGENCY ROOM COPAYMENT/COINSURANCE

When you are seen or treated in an Emergency room and are not directly admitted as an inpatient into a Hospital, you will be required to pay a Copayment/Coinsurance. The Copayment/Coinsurance amount you are required to pay is indicated in the COPAYMENT/COINSURANCE LIST.

Should you be admitted as an inpatient directly following your Emergency room visit, the Copayment/Coinsurance will be waived.

YEARLY MAXIMUM COPAYMENT/COINSURANCE LIMIT (does not include Copayments applying to Prescription Drugs and costs for non-Covered Services)

Anthem HMO Saver sets the following limits on the Copayment/Coinsurance you and your family has to make during any one Year. Once you or your family reaches one of these limits, no further Copayment/Coinsurance will be required for Covered Services for the remainder of that Year.

- For any MEMBER who is enrolled without any other Family Members (Subscriber only contract), by him or herself, the limit is $3,000.
- For a FAMILY, when two (2) Members of an enrolled family have met their Yearly Maximum Copayment/Coinsurance Limit, no further Copayment/Coinsurance will be required the remainder of that year.

Note: Copayments applying to Prescription Drugs, Emergency Room Copayments and costs for non-Covered Services and costs for Mental Health Services and Substance Abuse, except amounts you pay for Severe Mental Illnesses and Serious Emotional Disturbances of a Child do not apply toward the Yearly Maximum Copayment/Coinsurance Limit.

DEDUCTIBLE FOR CERTAIN SERVICES

There is a $1,500 Deductible per Member per Year which applies to certain services under this Agreement. The Deductible must be satisfied for the services listed below before these services are covered. Such services and/or care are covered only to the extent that the Covered Expense exceeds this Deductible. This Deductible is in addition to any other Deductible that may be required. This Deductible will apply toward satisfying your Yearly Maximum Copayment/Coinsurance Limit.

The following services are subject to the Deductible:

- Inpatient Hospital charges, excluding professional services.
- Outpatient Hospital facility charges (includes Emergency Room charges, except $100 Emergency Room Copayment).
- Ambulatory Surgical Centers.

See the COPAYMENT/COINSURANCE LIST for any Copayment/Coinsurance which may also apply to the above listed services.

COPAYMENT/COINSURANCE LIST

THE SERVICES OF THIS AGREEMENT ARE PROVIDED ONLY WHEN PERFORMED, PRESCRIBED, DIRECTED OR AUTHORIZED AS MEDICALLY NECESSARY BY A PHYSICIAN IN THE MEDICAL GROUP THE MEMBER HAS SELECTED. THIS LIST IS SUBJECT TO ALL PROVISIONS OF THE "YOUR BENEFITS" AND "WHAT IS NOT COVERED" SECTIONS OF THIS BOOKLET.

PHYSICIAN AND MEDICAL CARE

Visit to your Medical Group ..... $10 charge
Injections and injected substances ..... $10 charge
Allergy testing and treatment ..... $10 charge
Specialist consultations ..... $10 charge
Cancer screening tests and associated office visit
(this includes screening for cervical, ovarian and prostate cancer) ..... $10 charge
Surgery in Hospital or Medical Group and surgical assistants ..... No charge
Chemotherapy and radiation therapy ..... No charge
Administration of anesthetics ..... No charge
X-ray and laboratory procedures ..... No charge
Mammogram examinations ..... No charge
Physician visit to Member's home at the discretion of the Physician ..... $10 charge
Physician visit to Hospital or Skilled Nursing Facility
(excluding Mental or Nervous Disorders and Substance Abuse) ..... No Charge
Rehabilitative Care for other than Mental or Nervous Disorders and Substance Abuse (such as Physical Therapy, Occupational Therapy and/or Speech Therapy) will be provided. Members may receive these services for 60 consecutive days following an illness or injury, beginning with the first treatment for that illness or injury. Your Primary Care Physician makes the decision as to when each new illness or injury began. At the request of your Primary Care Physician, additional periods of care may be authorized, but only if your Medical Group or Anthem determines that an additional period of Rehabilitative Care is Medically Necessary. Your Medical Group or Anthem will authorize a specific number of additional visits.
Services rendered in an inpatient setting ..... No charge
Services rendered in an outpatient setting ..... $10 per visit

CARE FOR PREGNANCY AND MATERNITY

Any Copayments charged or applied for Prescription Drugs and costs for non-Covered Services will not apply toward the Yearly Maximum Copayment/Coinsurance Limit.

Note: No benefits are provided for a period of six (6) months following your effective date, for care or treatment of a pregnancy or any condition related to pregnancy (except treatment of a Complicated Pregnancy) when medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the Effective Date of this Agreement. However, if you were covered under Creditable Coverage within 62 days of becoming covered under this Agreement, the time spent under the Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

Professional Services for normal pregnancy care and Cesarean section deliveries,
Including prenatal and postnatal Physician office visits,
other covered professional services and covered outpatient services
are covered on the same basis as any other medical condition.
Inpatient Hospital and ancillary services in a
Contracting/Preferred Contracting Hospital after the Deductible ..... 20% of NFR
Complications of pregnancy, including therapeutic abortions ..... Same as any other condition
Elective abortions (Hospital facility charges are subject to the Deductible) ..... $250 charge
Genetic testing ..... No charge

FAMILY PLANNING

Sterilization for females, facility charges are subject to the Deductible and Copayments
Physician charge only ..... $250 charge

Sterilization for males, facility charges are subject to the Deductible and Copayments
Physician charge only ..... $150 charge

HOSPITAL SERVICES (subject to the Deductible)

In a Contracting/Preferred Contracting Hospital
365 days of care in a two bed room with ancillary services
excluding Mental or Nervous Disorders and Substance Abuse ..... 20% of the NFR

Operating room and special treatment rooms - inpatient stays ..... 20% of the NFR

Intensive care ..... 20% of the NFR

Nursing care, including private nursing if Medically Necessary ..... 20% of the NFR

The inpatient Hospital stay associated with Organ and Tissue transplants ..... 20% of the NFR

Outpatient Hospital/Ambulatory Surgical Center services,
including surgical stays ..... 20% of the NFR

Chemotherapy/Radiation ..... 20% of the NFR

Blood, blood plasma, blood derivatives and blood factors ..... 20% of the NFR

Inpatient Drugs, medications and oxygen ..... 20% of the NFR

Surgically implanted devices (for device only)
facility charges are subject to the Deductible
and any applicable Copayment/Coinsurance ..... 20% of the NFR

Outpatient Surgical and anesthetic supplies ..... 20% of the NFR

Dialysis Centers ..... 20% of the NFR

SKILLED NURSING FACILITY SERVICES

100 days of care each Year in a two bed room with ancillary services
including Severe Mental Illnesses and Serious Emotional Disturbances of a Child
(excluding Mental and Nervous Disorders and Substance Abuse) ..... No charge

EMERGENCY SERVICES (Emergency Room and Hospital inpatient are subject to the Deductible)

Professional services including Billed Charges by Non-Participating Providers ..... No charge

Emergency room Hospital outpatient services and procedures performed
in the Emergency room, including X-ray and laboratory charges ..... $100 PLUS 20% of the NFR

Hospital inpatient services ..... 20% of the NFR

Note: For information on Emergency room Copayment/Coinsurance, see Emergency Room Copayment/Coinsurance above.

HEALTH MAINTENANCE CARE

Note: Some health education and medical social services programs may be subject to a Copayment/Coinsurance. Check with your HMO coordinator for the amount, if any.

Specified immunizations ..... $10 charge

Periodic check-ups ordered by Primary Care Physician ..... $10 charge

Physical examinations ordered by Primary Care Physicians ..... $10 charge

Vision and hearing examinations ..... $10 charge

Medical social services ..... No charge

Health education - selected programs ..... No charge

Home Health Visit ordered by Primary Care Physician
limit of three (3) two-hour visits each day;
maximum of 100 visits per Year ..... No charge
All services other than Hospital services associated with Organ and tissue transplants ..... No charge
Prosthesis (replacement of body parts) ..... No charge
Hemodialysis ..... No charge
Well Baby Care and Well Child Care ..... $10 charge
Durable Medical Equipment
limited to a combined maximum of $2,000 per Member per Year
for all settings and uses ..... 20% of the NFR

PSYCHIATRIC SERVICES FOR MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

Note: No inpatient benefits are provided except for treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child as described below.

Outpatient Care:

Psychotherapy, Rehabilitative Care or
Psychological testing when ordered by a Primary Care Physician
excluding psychoanalysis; 20 visit limit each Year, for Rehabilitative Care, additional visits as authorized by your Medical Group or Anthem if Medically Necessary. ..... $25 per visit

Severe Mental Illnesses and Serious Emotional Disturbances of a Child are covered on the same basis as any other medical condition.

ACUTE ALCOHOLISM AND DRUG ADDICTION

Inpatient Care (Detoxification Only)

Inpatient detoxification for alcohol or drug abuse after the Deductible ..... 20% of the NFR

Severe Mental Illnesses and Serious Emotional Disturbances of a Child are covered on the same basis as any other medical condition.

AMBULANCE SERVICES

Note: If the Member is admitted as an inpatient, there is no charge to the Member.

Ground ambulance ordered by Primary Care Physician ..... $50 charge
Air ambulance ordered by Primary Care Physician ..... $50 charge

PART IV YOUR BENEFITS

WHAT IS COVERED

The following services and supplies are provided for the treatment of a covered illness, injury or condition. The services must be AUTHORIZED BY YOUR PRIMARY CARE PHYSICIAN OR OBSTETRICIAN/ GYNECOLOGIST.

HOSPITAL
In California, services must be received in a Contracting Hospital.

Inpatient
The following services of a Hospital are provided:
- Accommodations are covered in a room of two or more beds. If a private room is used, you will be responsible for the cost in excess of 100% of the prevailing charge for two-bed room accommodations.
- Services in Special Care Units.
- Operating, delivery and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines approved for general use by the Food and Drug Administration, which are supplied by the Hospital for use during the Member's Hospital stay.
- Use of the Emergency room.
- Outpatient services and supplies, including those in connection with outpatient surgery performed at an Ambulatory Surgical Center.

Admissions for Detoxification (Acute Alcoholism and Drug Addiction)

The following services of a Hospital are provided:
- The same inpatient Hospital services that are provided for any other condition. Services are provided for detoxification only.

  Severe Mental Illnesses and Serious Emotional Disturbances of a Child are covered on the same basis as any other medical condition.

Note: No benefits are provided for drug or alcohol rehabilitation.

Outpatient
The following services of a Hospital are provided:
- Emergency room use, supplies, ancillary services, drugs and medicines as listed under Psychiatric Services For Mental or Nervous Disorders and Substance Abuse, Inpatient Care-Detoxification Only (see COPAYMENT/COINSURANCE LIST).
- Care received when outpatient surgery is performed. Covered Services are operating room use, supplies, ancillary services, drugs and medicines as listed above under Hospital-Inpatient.
- Radiation therapy, chemotherapy and dialysis treatment.

SKILLED NURSING FACILITY (Limited to 100 days per Year)
- You must be under the active supervision of a Physician treating your illness or injury.
- A room with two or more beds.
- Special treatment rooms.
- Laboratory tests.
- Physical therapy, occupational therapy and speech therapy limited to a combined maximum of 60 consecutive days in all settings. Oxygen and other respiratory therapy.
- Drugs and medicines given to you during your stay.
- Blood transfusions, including the cost of blood, blood products or blood processing.

PROFESSIONAL SERVICES AND SUPPLIES

- Services of a Physician, including surgeons and specialists.
- Visits during a covered inpatient stay, limited to one a day unless additional visits are needed due to the Member's medical condition. Visits include those during medical Hospital stays and those during stays in a Skilled Nursing Facility.
- Office visits for a covered illness, or condition, limited to one visit a day (see COPAYMENT/COINSURANCE LIST).
- Services of an anesthesiologist or an anesthetist.
- Outpatient diagnostic radiology and laboratory services.
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the office visit associated with performing those tests when ordered by your Primary Care Physician. This includes screening for breast cancer, ovarian and cervical cancer screening tests, including the human papilloma virus (HPV) test for cervical cancer, and prostate specific antigen (PSA) testing.
- Human Immunodeficiency Virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
- Prosthetic devices related to a laryngectomy.
- Mammogram examinations when ordered by your Primary Care Physician.
- Radiation therapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Autologous blood donations will be covered only when the blood is transfused back into the patient.
- Routine physical examinations and immunizations (see COPAYMENT/COINSURANCE LIST).
- Rehabilitative Care (such as Physical Therapy, Occupational Therapy, and/or Speech Therapy), will be provided. Members may receive theses services for 60 consecutive days following an illness or injury, beginning with the first treatment for that illness or injury. Your Primary Care Physician makes the decision as to when each new illness or injury began (see COPAYMENT/COINSURANCE LIST). At the request of your Primary Care Physician, additional periods of care will be authorized, but only if your Medical Group or Anthem determines that an additional period of Rehabilitative Care is Medically Necessary. Your Medical Group or Anthem will authorize a specific number of additional visits.
- FDA approved medications that may only be dispensed by or under direct supervision of a Physician.
- Genetic testing and diagnostic procedures for Members when Medically Necessary to treat an inheritable disease.
- Immunizations for diphtheria, pertussis, tetanus, measles, mumps, poliomyelitis, whooping cough and rubella. Hepatitis B and gamma globulin, pneumonia, influenza, H influenza and varicella zoster (chicken pox) vaccines are covered only when prescribed by your Primary Care Physician.
- Reconstructive Surgery. **Note:** Reconstructive Surgery is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function (2) to create normal appearance, to the extent possible.
- Prosthetic devices to achieve symmetry after mastectomy.
- Visits to the Member's home within the Medical Group Area, by a Primary Care Physician, at that Physician's discretion (see COPAYMENT/COINSURANCE LIST).
- Outpatient psychotherapy or psychological testing (except psychoanalysis), limited to one visit a day and 20 visits each Year (except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child) (see COPAYMENT/COINSURANCE LIST).
- Vision and hearing examinations (see COPAYMENT/COINSURANCE LIST).
- Allergy testing and treatment (see COPAYMENT/COINSURANCE LIST).
- Well Baby and Well Child Care (see COPAYMENT/COINSURANCE LIST).
- Family planning services, counseling and planning (see COPAYMENT/COINSURANCE LIST).
- Health education services and education in the appropriate use of the HMO Saver.
- General anesthesia and associated facility charges for dental procedures in a Hospital or surgery center for enrolled Members:
  a. Under seven (7) years of age.

b. Developmentally disabled, regardless of age.
c. Whose health is compromised and general anesthesia is Medically Necessary, regardless of age.

- Ambulance service (base charge, mileage and non-reusable supplies) to transport you to or from a Hospital or Skilled Nursing Facility when Medically Necessary. Payment of benefits for ambulance services will be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid. If you requested through a 911 call, ambulance charges are covered if you reasonably believed that a medical Emergency existed even if you are not transported to a Hospital.

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

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

PROSTHESIS AND SUPPLIES

- Prosthetic devices that replace missing body parts, including but not limited to:
  - Artificial limbs and eyes.
  - Surgical implants.
  - Implanted lenses replacing organic eye lenses.
  - Prosthetic devices to achieve symmetry after mastectomy.
- Colostomy supplies.
- Supplies required to maintain prosthetic devices.

DURABLE MEDICAL EQUIPMENT

Rental or purchase of dialysis equipment and dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

- Of no further use when medical needs end;
- For the exclusive use of the patient;
- Not primarily for comfort or hygiene;
- Not for environmental control or for exercise; and
- Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above. Rental charges that exceed the reasonable purchase price of the equipment are not covered. **We will pay no more than a total of $2,000 combined under the Home Health Care and/or Durable Medical Equipment benefit toward charges you incur for Durable Medical Equipment in a Year.**

Inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s). These services and supplies for the management and treatment of asthma are not subject to the $2,000 Yearly maximum indicated above.

Medical Supplies and Equipment will not include coverage for: orthopedic shoes or shoe inserts, footwear, arch supports, disposable sheaths and supplies, correction appliances or support appliances, and supplies such as stockings or personal comfort items as indicated in the PART entitled WHAT IS NOT COVERED.

WIGS

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

SMOKING CESSATION

We will pay up to $50 per Member per lifetime toward any smoking cessation program designed to end the dependence on nicotine.

PREGNANCY AND MATERNITY CARE

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

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

WELL BABY AND WELL CHILD CARE

For Members up to and including 6 years of age only for office visits and/or services received in a physician's office.

The following services are covered:

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

TREATMENT FOR DIABETES

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

1. The following Diabetes Equipment and Supplies:

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

   These covered equipment and supplies are covered under your plan's benefits for durable medical equipment (see Durable Medical Equipment).

2. Diabetes Outpatient Self Management Training Program which:

   - Is designed to teach a member who is a patient, and covered members of the patient's family about the disease process and the daily management of diabetic therapy;
   - Includes self management training, education, and medical nutrition therapy to enable the member to properly use the equipment, supplies and medications necessary to manage the disease; and
   - Is supervised by a Physician.

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

3. The following items are covered under your prescription drug benefits:

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

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

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

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

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

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

OUTPATIENT CARE FOR MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE
Outpatient psychotherapy, Rehabilitative Care (such as Physical Therapy, Occupational Therapy and/or Speech Therapy) or psychological testing, performed by a Physician, limited to one visit per day and 20 visits each Year except Severe Mental Illnesses and Serious Emotional Disturbances of a Child and, for Rehabilitative Care, additional visits as authorized by your Medical Group or Anthem if Medically Necessary.

Note: The term Physician is defined in this Agreement to include a variety of licensed practitioners of the healing arts, including those who normally provide rehabilitative services.

TREATMENT FOR SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD
Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illnesses and Serious Emotional Disturbances of a Child (see the PART entitled DEFINITIONS) will be provided at the same levels of coverage as other medical diagnoses, and will be subject to all other terms, conditions, limitations, and exclusions, including Maximum Comprehensive Benefits.

CANCER CLINICAL TRIALS

If a Member is diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer, Anthem will cover all routine patient care costs related to the clinical trial on the same basis as any other medical condition if the Member's treating physician, who is providing the health care services to the Member under this Agreement, recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Member. The clinical trial must have a therapeutic intent and not just be to test toxicity. Benefits are paid on the same basis as any other medical condition and are subject to any applicable Copayments, Coinsurance and Deductibles.

Coverage for clinical trials is restricted to Participating Providers in California unless the protocol for the clinical trial is not provided for at a California Hospital or California Physician. In which case, Covered Services for a clinical trial provided by a Non-Participating Provider will be paid based on the Negotiated Fee Rate subject to any applicable Copayments, Coinsurance and/or Deductibles. The Member will be responsible for charges in excess of the Negotiated Fee Rate.

The treatment provided in a clinical trial must either:

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

Covered Services include costs associated with the provision of the health care services, including drugs, items, devices and services which would otherwise be covered under this plan, including"

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the investigational drug, item, device or service
- Health care services required for the clinically appropriate monitoring of the investigational item or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service.
- Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

Covered Services will <u>not</u> include the following:

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

Note: You will be financially responsible for the costs associated with non-covered services.

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

REHABILITATIVE CARE (for other than Mental or Nervous Disorders and Substance Abuse)
Rehabilitative Care (such as Physical, Occupational and/or Speech Therapy) will be provided. 60 consecutive days following an illness or injury, beginning with the first treatment for that illness or injury (see COPAYMENT/COINSURANCE LIST). Your Primary Care Physician makes the decision as to when each new illness or injury began. At the request of your Primary Care Physician, additional periods of care will be authorized, but only if your Medical Group or Anthem determines that an additional period of Rehabilitative Care is Medically Necessary. Your Medical Group or Anthem will authorize a specific number of additional visits.

HOME HEALTH CARE
The following services of a Medicare certified Home Health Agency or Visiting Nurse Association are provided, up to three two-hour visits each day and a maximum of 100 visits per Year:

- Services of a registered nurse.
- Services of a licensed therapist for physical therapy, occupational therapy and speech therapy.
- Services of a medical social worker.
- Services of a health aide who is employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. Services must be ordered and supervised by a registered nurse who is employed as a professional by the same organization. These services are covered only if the Member is also receiving the services listed in the 1st or 2nd bullet above.
- Medically Necessary supplies provided by the Home Health Agency or Visiting Nurse Association. **We will pay no more than a total of $2,000 combined under the Home Health Care and/or Durable Medical Equipment benefit toward charges you incur for Durable Medical Equipment in a Year.**

Note: Benefits will be provided only if the Member receiving these services is homebound.

INFUSION THERAPY
(Administration of drugs and other substances in ways other than oral, such as chemotherapy through a vein.)

A **Course of Therapy** is defined as Physician prescribed Infusion Therapy which has been authorized by your Medical Group or Independent Practice Association.

Covered Services include:

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

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

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs adhesive bandages and intravenous starter kits. No separate benefit is provided for these services and supplies. These services and supplies are included in the charges for the drugs and durable medical equipment used.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled “Caution, limited by Federal Law to Investigational use” or Drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.

Charges by a Non-Participating Provider, except in an Emergency or with Authorization pursuant to an authorized referral.

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

ORGAN AND TISSUE TRANSPLANTS
All services provided for any other covered condition are provided in connection with a non-investigative organ or tissue transplant for:

1. An enrolled Member who receives the organ or tissue, and
2. An organ or tissue donor who is not an enrolled Member, if the organ or tissue recipient is an enrolled Member. Benefits are reduced by any amounts paid, or payable, by that donor's own coverage.

This benefit is not extended to an enrolled Member who donated the organ or tissue unless the recipient is also an enrolled Member.

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.

PART V WHAT IS NOT COVERED

No benefits are provided for or in connection with the following:

ANY SERVICES NOT AUTHORIZED BY A PRIMARY CARE PHYSICIAN, MEDICAL GROUP EXCEPT AS EXPRESSLY PROVIDED HEREIN.

Note: Authorization does not apply to Severe Mental Illnesses and Serious Emotional Disturbances of a Child and Obstetrician/Gynecologists.

Acupuncture and Acupressure.

Any amounts in excess of Customary and Reasonable charges for care rendered by a Non-Participating Provider without a Referral from a Primary Care Physician. See the definition of Non-Participating Provider.

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

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

Dental Services: Dentures, bridges, crowns, caps, clasps, habit appliances, partials, or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums. **Dental Implants:** (materials implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants. **Orthodontic Services:** Braces, other orthodontic appliances, orthodontic services.

Durable medical equipment, except as specifically stated under the PART entitled YOUR BENEFITS in the section WHAT IS COVERED, including but not limited to orthopedic shoes or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment, swimming pools, spas, treadmills, elevators, supplies for comfort, hygiene or beautification, medical-surgical supplies for home use, correction appliances or support appliances, and supplies such as stockings.

Educational Services.

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

Eye exercises and orthoptics. Optometric services except for eye examinations to determine the need for vision correction. Eyeglasses or contact lenses, except an implanted lens which replaces the organic eye lens as specifically stated under the PART entitled YOUR BENEFITS in the section, WHAT IS COVERED.

Eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia).

Food or Dietary Supplements, except for formulas and special food products as specifically stated under the section PHENYLKETONURIA (PKU) in the PART entitled YOUR BENEFITS- WHAT IS COVERED. They must be prescribed by a Physician in consultation with a metabolic disease specialist if it is deemed Medically Necessary to prevent complications of PKU. Coverage is only to the extent that the prescribed formulas and special food products exceeded the cost of a normal diet.

Genetic Testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality.

Government Services: Any services you actually received that were provided by a local, state or federal government agency except when payment under this Agreement is expressly required by federal or state law. Anthem will not cover payment for these services 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.

Hearing aids.

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

Immunizations for foreign travel. Immunizations not specifically stated under the PART entitled YOUR BENEFITS- WHAT IS COVERED.

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

Injuries sustained during the commission, or attempted commission, **of a felony** or any illegal act, riot or civil insurrection.

Inpatient room and board charges in connection with a Hospital stay primarily **for environmental change**, physical therapy or treatment of chronic pain. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated under Skilled Nursing Facility in the PART entitled YOUR BENEFITS – WHAT IS COVERED.

Medical, surgical and/or psychological treatment of a sexual dysfunction except when a sexual dysfunction is the result of a physical abnormality, defect or disease.

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

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

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

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

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

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

Nutritional counseling, except for Diabetes.

Outdoor Treatment Programs.

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

Pre-existing pregnancies. No benefits are provided for care or treatment of a pregnancy or any condition related to pregnancy (except treatment of a Complicated Pregnancy) during the first six (6) months of coverage under this Agreement when medical advice, diagnosis, care or treatment, including the use of Prescription Drugs was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the Effective Date of this Agreement. 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, this limitation does not apply to a Federally Eligible Defined Individual, or a child born to or newly adopted by an enrolled subscriber, spouse or Domestic Partner. If you were covered under Qualifying Prior Coverage within 62 days of becoming covered under this Agreement, the time spent under Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

Pregnancy or maternity care for other than the Subscriber, Spouse or Domestic Partner.

Prescription Drugs and medication, unless prescribed to a registered bed patient in a Hospital or Skilled Nursing Facility, or administered in an authorized Home Health Agency program except as specifically provided in this Agreement under the PART entitled YOUR PRESCRIPTION DRUG BENEFITS.

Purchase or replacement of artificial limbs or prosthesis unless the medical condition creating the need for the limb or prosthesis occurred while the Member was covered under this Agreement.

Rehabilitative care, such as Physical Therapy, Occupational Therapy and/or Speech Therapy, unless provided by a Home Health Agency or a Visiting Nurse Association or except as specifically stated in Professional Services and Supplies under the PART entitled YOUR BENEFITS – WHAT IS COVERED.

Routine physical examinations or tests which do not directly treat an actual illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization, be covered unless Medically Necessary.

Services not specifically listed in this Agreement as Covered Services.

Services received after the benefit limit under this Agreement is reached.

Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends, except as specifically stated in this Agreement.

Services which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

- It must be internationally known as being devoted mainly to medical research, and
- At least ten percent of its Yearly budget must be spent on research not directly related to patient care, and
- At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and
- It must accept patients who are unable to pay, and
- Two-thirds of its patients must have conditions directly related to the Hospital's research.

Sex Changes: Procedures or treatments to change characteristics of the body to those of the opposite sex.

Surrogacy. Any services or supplies provided to any person not covered under this Agreement in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple.

Telephone and facsimile machine consultations. Consultations provided by telephone or facsimile machines.

Treatment of the joint of the jaw and/or Occlusion (the way upper and lower teeth meet). Services, supplies or appliances provided in connection with any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporomandibular joint) for any reason or by any means except any Medically Necessary (as determined by Anthem) surgical procedure required to treat the upper or lower jawbone, or associated bone joints, or occurring while the Member is covered under this Agreement.

Weight Reduction: Services primarily for weight reduction, treatment of obesity, or any care which involves weight reduction as a main method of treatment except Medically Necessary treatment of morbid obesity.

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, Anthem will provide the benefits of this plan for such conditions subject to its right to lien or other recovery under California Labor Code Section 4903 or other applicable law.

PART VI 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 Combined Evidence of Coverage and Disclosure Form.

Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and other services wherever they are rendered, are reviewed by Anthem for medical necessity. The review processes which may be undertaken are listed below in the paragraphs entitled **Preservice Review, Admission Review, Continued Stay Review and Retrospective Review**.

The Anthem Utilization Review Program evaluates the medical need for Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child. This means that the Facility Based Treatment is Medically Necessary.

You are always responsible for initiating Preservice Review. Whenever Preservice Review has not been performed for services that require Preservice Review, you will be required to pay a $250 Copayment for that admission, treatment or therapy. This Copayment is in addition to any other Copayment required by this Combined Evidence of Coverage and Disclosure Form.

To initiate Preservice Review, instruct your Physician to request Preservice Review at least three (3) working days before any scheduled Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child by calling Anthem at 1-800-274-7767. But remember, you are responsible to see that it is done.

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

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

If you obtain services for Facility Based Treatment for Substance Abuse, Severe Mental Illnesses and Serious Emotional Disturbances of a Child in a Medical Emergency, the $250 Copayment will not be charged whether or not you were admitted to a facility.

Preservice Review is required for Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child. Anthem will determine in advance whether these services are Medically Necessary and are the appropriate length of stay.

Admission Review. Anthem will determine at the time of admission if the Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child is Medically Necessary in the event Preservice Review is not conducted. No benefits will be provided if we determine that the Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child is not Medically Necessary.

Continued Stay Review. Anthem will also determine if continuing Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child is Medically Necessary.

Retrospective Review. Anthem will determine if a scheduled or Medical Emergency admission for Facility Based Treatment for Substance Abuse, Severe Mental Illnesses or Serious Emotional Disturbances of a Child was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

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

PART VII YOUR PRESCRIPTION DRUG BENEFITS

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

Anthem Blue Cross uses a preferred list of Drugs, sometimes called a formulary, to help your doctor make prescribing decisions. This list of Drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes Drugs that are safe and effective in the treatment of disease. The presence of a drug on the plan's formulary does not guarantee that it will be prescribed. If you have a question regarding whether a Drug is on the Anthem Preferred Drug List, please call 1-800-700-2533.

Some medications may require written prior authorization from Anthem. Please call 1-800-700-2533 for a list of these medications.

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

Definitions

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

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

Drug Limited Fee Schedule is the maximum amount that Anthem will consider as a Covered Expense when your Prescription is filled at a Non-Participating Pharmacy, and is the lesser of billed charges or the Average Wholesale Price (AWP). The AWP is the average of the list prices that the manufacturers producing the Drug suggest that a wholesaler charge a Pharmacy for the Drug.

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

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

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

Negotiated Fee is the fee that Anthem has negotiated with the Participating Pharmacy under a Participating Pharmacy agreement for covered expense. Participating Pharmacies have agreed to charge eligible HMO Saver Members no more than the Negotiated Fee for covered Prescriptions.

Non-Participating Pharmacy is a Pharmacy which does not have a Participating Pharmacy agreement in effect with Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

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

Pharmacy means a licensed retail Pharmacy.

Prescription means a written order issued by a Physician.

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

Your Prescription Drug benefits are as follows:

What is Covered

- Generic Drugs will be dispensed by Participating Pharmacies unless the Prescription specifies a Brand Name and states "dispense as written" or "do not substitute," or no Generic equivalent exists. However, any Copayment made for a Brand Name Drug that has been specified by your Physician to "dispense as written' or "do not substitute" when a Generic Drug equivalent exists, the Anthem Negotiated Fee (Participating Providers) or the Drug Limited Fee Schedule (Non-Participating Pharmacies) for that Brand Name Drug will **not** be applied towards the Brand Name Prescription Drug Deductible.
- Outpatient Drugs and medications which Federal and/or State of California law restrict to sale by Prescription only.
- Insulin. Insulin syringes prescribed and dispensed for use with insulin. Lancets and test strips for use in monitoring diabetes.
- All non-infused compound Prescriptions which contain at least one covered Prescription ingredient.
- All compound Prescriptions which contain at least one covered Prescription ingredient.
- Oral contraceptive Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA-approved prescription contraceptive method will be provided.
- Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction. These Drugs and medications must be authorized in advance by Anthem and are limited to eight (8) tablets/units per thirty (30)-day period.
- Phenylketonuria (PKU) formulas and food products. These formulas are subject to the Copayment for Brand Name Drugs and the Brand Name Prescription Deductible.

Brand Name Deductible

Each Member must meet a Brand Name Prescription Deductible amount of $250 each Year under this program. This Deductible is separate from the annual medical Deductible and does not accumulate toward the medical Yearly Maximum Copayment/Coinsurance Limit. This Brand Name Prescription Deductible applies to Brand Name Prescription Drugs purchased through the Mail Order Prescription Drug Program and at Participating and Non-Participating Pharmacies combined. However, any Copayment made for a Brand Name Drug that has been specified by your Physician to "dispense as written" or "do not substitute" when a Generic Drug equivalent exists, the Anthem Negotiated Fee (Participating Pharmacies) or the Drug Limited Fee Schedule (Non-Participating Pharmacies) for that Brand Name Drug will **not** be applied towards the Brand Name Prescription Drug Deductible. The first two (2) Members of an enrolled family to satisfy their Brand Name Deductible in full will satisfy this Deductible for the entire family. Once the family Brand Name Deductible is satisfied, no further Brand Name Deductible is required for the remainder of that Year. However, we will not credit any Brand Name Deductible over and above the family Brand Name Deductible maximum that was applied but did not satisfy an individual Member's Brand Name Deductible amount in full.

Conditions of Service

The Drug or medicine must:

- Be prescribed in writing by a Physician and be dispensed by a licensed retail pharmacist or by mail through the Mail Order Prescription Drug Program within one year of being prescribed, subject to federal or state laws.
- Be approved for use by the Food and Drug Administration.
- Be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included.
- Be purchased from a licensed retail Pharmacy or ordered by mail through the Mail Order Prescription Drug Program.
- Not be used while the Member is an inpatient in any facility.
- Be listed on the Anthem Outpatient Prescription Drug Formulary at the time of dispensing if purchased through the Mail Order Prescription Drug Program.

The retail Prescription must not exceed a 30-day supply. The Prescription ordered through the Mail Order Prescription Drug Program must not exceed a maximum 60-day supply.

Drug Utilization Review
Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require prior authorization. If there are patterns of over-utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.

Revoking or modifying a prior authorization
A prior authorization of benefits for prescription drugs may be revoked or modified prior to your receiving the drugs for reasons including but not limited to the following:
- Your coverage under this plan ends;
- You reach a benefit maximum that applies to prescription drugs, if the plan includes such a maximum;
- Your prescription drug benefits under the plan change so that prescription drugs are no longer covered or are covered in a different way.

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

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

For Drugs on the Anthem Formulary:

- $10 Copayment for Generic Drugs.
- 100% of Negotiated Fee Rate for Brand Name Drugs until a $250 Brand Name Prescription Drug Deductible is satisfied
- After the $250 Brand Name Prescription Drug Deductible is satisfied:
  - $30 Copayment for Brand Name Drugs if a Generic equivalent is not available.
  - $10 Copayment plus the difference in cost based on the Negotiated Rate when purchased at a Participating Pharmacy between the Brand Name and the Generic equivalent for Brand Name Drugs if a Generic equivalent is available.*
- 30% of the Negotiated Fee Rate for Self-Administered Injectable Drugs, except for insulin.

For Drugs **not** on the Anthem Formulary:

- 50% of the Negotiated Fee Rate for Generic Drugs.
- 100% of the Negotiated Fee Rate for Brand Name Drugs until $250 Brand Name Prescription Drug Deductible is satisfied
- After the $250 Brand Name Drug Deductible** has been satisfied:
  - 50% of the Negotiated Fee Rate for Brand Name Drugs if a Generic Equivalent is not available
  - $10 Copayment **plus** the difference in cost, based on the Negotiated Fee Rate when purchased at a Participating Pharmacy, between the Brand Name and the Generic Equivalent for Brand Name Drugs if a Generic Equivalent is available.
- 30% of the Negotiated Fee Rate for Self-Administered Injectable Drugs, except for insulin.

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

**Both Formulary and Non-Formulary brand name drugs count toward the $250 Brand Name Drug Deductible.

All Prescriptions and authorized refills purchased at a Participating Pharmacy are limited to a 30-day supply.

When You Go to a Non-Participating Pharmacy (inside or outside the State of California)
If you purchase a Prescription Drug from a Non-Participating Pharmacy, you will have to pay the full cost of the Drug and submit a claim form to Anthem at the address below:

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

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

Non-Participating Pharmacies do not have claim forms for your Prescription Drug Plan. You must take a claim form with you to Non-Participating Pharmacies so the pharmacist can complete the Pharmacy's portion of the form and sign it.

The rate of reimbursement by Anthem

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

Refer to the Definitions section of the PART for the definition of Drug Limited Fee Schedule.

Note: This plan covers Generic Drugs **only**, unless a Generic equivalent does not exist or your Physician requests no substitutions. All Prescriptions and authorized refills purchased at a Non-Participating Pharmacy are limited to a 30-day supply.

Mail Order Prescription Drug Program
Maintenance Drugs (an ongoing Prescription) can be purchased by mail, requiring the following Copayment to be submitted for each Prescription. The following Copayment applies:

- **Generic Drugs:** $10 Copayment for each Prescription and/or refill for each 30-day supply or a $20 Copayment up to a 60-day supply for Generic Formulary Drugs.
- **Brand Name Drugs:** After $250 Brand Name Prescription Drug Deductible is satisfied:
  - You pay a $30 Copayment for each Prescription and/or refill for each 30-day supply or a $60 Copayment for up to a maximum 60-day supply if a Generic equivalent is not available.
  - You pay a $10 Copayment **plus** the difference in cost between the Brand Name and the Generic equivalent for each Prescription and/or refill for each 30-day supply or a $20 Copayment **plus** the difference in cost between the Brand Name and the Generic equivalent for each Prescription and/or refill for up to a maximum 60-day supply if a Generic equivalent is available.

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

The Prescription must state the product name, strength, days supply, number of refills (if permitted), and your name and address. It must be signed by your Physician. The first Mail Order Prescription you submit must include a completed Patient Profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent Mail Order Prescriptions for that Member need only the Prescription and Copayment to be enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the Anthem designated Mail Order Pharmacy.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Mail Order Prescription Drug Program (including, but not limited to: Drugs not on the formulary, injectables including Self-Administered Injectables except insulin, and antibiotics). Please check with the Mail Order Prescription Drug Program customer service department at 1-866-274-6825 for availability of the Drug or medicine.

Specialty Drug Fulfillment

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

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

You may obtain a list of specialty drugs available through the PrecisionRx Specialty Solutions network by contacting Member Services toll free at 1-800-870-6419 or by accessing our website at www.anthem.com/ca.

Prescription Drug Exclusions and Limitations

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

- Any expense incurred in excess of the Drug Limited Fee Schedule at a Non-Participating Pharmacy.
- Drugs and medications which may be obtained without a Physician's Prescription, except insulin and niacin for cholesterol lowering.
- Prescription Drugs which have non-prescription chemical and dosage equivalents.
- Non-medicinal substances or items.
- Pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches), over the counter remedies or any Prescription product containing nicotine. While not covered under this Prescription Drug benefit, under the PART entitled YOUR BENEFITS, pharmaceuticals to aid smoking cessation (e.g., Nicorette or nicotine patches) are specified as covered under the section describing benefits for "Smoking Cessation", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Contraceptive devices prescribed for birth control except as specifically stated under the section entitled What is Covered under this PART entitled YOUR PRESCRIPTION DRUG BENEFITS. Also, under the PART entitled YOUR BENEFITS, contraceptive implants and associated professional services are specified as covered under the section describing benefits for "Professional Services and Supplies", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Drugs and medications used to induce non-spontaneous abortions. While not covered under this Prescription Drug benefit, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are specified as covered under the section of the PART entitled YOUR BENEFITS describing benefits for "Professional Services and Supplies", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Dietary supplements, herbs, vitamins, cosmetics, health or beauty aids, or similar products which are not FDA approved to treat, diagnose, prevent, or cure a medical condition. However, you will want to know the following:

- Under the PART entitled YOUR BENEFITS, formulas for the treatment of phenylketonuria are specified as covered under the section describing benefits for treatment of "Phenylketonuria", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.
- Under the PART entitled YOUR BENEFITS, health aids that are medically necessary and satisfy the definition of durable medical equipment, will be covered under the section describing benefits for "Durable Medical Equipment", subject to all terms of this Combined Evidence of Coverage and Disclosure Form that apply to those benefits.

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

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

Claims and Customer Service

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

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

or call customer service at 1-800-700-2533

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

Anthem Blue Cross Mail Order Prescription Drug Program
P.O. Box 961025
Fort Worth, TX 76161-9863

or call 1-866-274-6825

PART VIII DURATION AND TERMINATION OF YOUR AGREEMENT AND OUR RIGHT TO MODIFY YOUR AGREEMENT

The Effective Date of your coverage is printed on your Anthem Blue Cross Identification Card.

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

A. Anthem may, at any time, terminate, cancel or decline to renew this Agreement in the event of any of the following:

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

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

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

2. For fraud or intentional misrepresentation of a material fact in the submission of claims or the use of services or facilities of Anthem, or your knowingly permitting such fraud or deception by another. This Agreement 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 Agreement. Termination is effective on the date of mailing the written notice.

3. On the first of the month following our receipt of your written notice to cancel.

4. Your coverage may end if you become ineligible as stated in the section, When the Member Becomes Ineligible, in the PART entitled ELIGIBILITY. Your coverage will end on the date specified in the notice, but not earlier than thirty-one (31) days after the date of the notice.

5. If we decide to leave the individual market or cease to offer individual PPO or HMO coverage in the state or in the HMO service area and if we have given the Director of the Department of Managed Health Care at least 180 days prior written notice, we may not renew this Agreement. Any non-renewal shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 180 days following the date of the notice

6. If we decide to discontinue this plan and if we have given the Director of the Department of Managed Health Care at least 90 days prior written notice, we may terminate this Agreement. We will give you written notice of any such termination, and any such termination shall be effective on the date and at the time specified in the notice, but it will in no event be earlier than 90 days following the date of the notice. We would make available continued coverage under any of the other plans we offer to individuals, without regard to your health status.

7. If you are in the Hospital or Skilled Nursing Facility on the date we cancel your coverage on written notice as described in Paragraph 6, benefits will continue until whichever of the following occurs first:

   a. The date of discharge from the Hospital or Skilled Nursing Facility, or
   b. Care or treatment is no longer Medically Necessary, or
   c. The maximum benefits have been furnished.

B. We have the right to modify this Agreement, including change subscription charges, if we give you thirty (30) days written notice.

1. We will not modify this Agreement on an individual basis, but only for all Members in the same class and covered under the same plan as you.
2. The modification will take effect on the date listed in the notice.

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

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

C. In addition to the right to terminate, cancel or decline to renew the Agreement set forth in Paragraph A., Anthem has the right upon renewal, or at any time during the duration of your Agreement, to modify or otherwise change benefits, terms and conditions of your Agreement, **including subscription charges**, provided that Anthem gives you thirty (30) days prior written notice from the postage paid mailing date of such modifications or changes. Such modifications or changes may alter or otherwise change the benefits, terms and conditions of this Agreement, including without limitation, subscription charges, covered benefits, Deductibles, copayments or coinsurance. Anthem can modify or change the terms and conditions of your Agreement at any time during the Year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.

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

1. Anthem will not modify this Agreement under Paragraph F. on an individual basis, but only for all Members in the same class and covered under the same plan as you.
2. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph B., above) on or after the 30th day following the date of the above notice.

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

You should address any written notice to us at the following address:

Anthem Blue Cross
P. O. Box 9051, Oxnard
California 93031-9051

PART IX CONVERSION PRIVILEGE

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

  The type of coverage offered will be at the discretion of the new Blue Cross or Blue Shield Plan.
- SERVICES, BENEFITS AND SUBSCRIPTION CHARGES UNDER A CONVERSION AGREEMENT OR MEDICARE SUPPLEMENT MAY NOT BE THE SAME AS THOSE PROVIDED UNDER THIS AGREEMENT.

PART X GRIEVANCE PROCEDURE

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

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

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

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

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

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

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

- The Member has a life threatening or seriously debilitating condition.
  - A life threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
  - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The proposed treatment must be recommended by a Participating Physician, or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
- If independent medical review is requested by the Member or by a qualified Non-Participating Physician, as described above, the requester must supply two items of acceptable scientific support (as defined below).

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

"Acceptable 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;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

Independent Medical Review of Grievances involving a Disputed Health Care Service

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

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

Eligibility:

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

1. a. Your provider has recommended a health care service as Medically Necessary, or
   b. You have received urgent care or emergency services that a provider determined was Medically Necessary, or
   c. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by us based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

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

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

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

Department of Managed Health Care

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

PART XI 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. It is understood that any dispute including disputes relating to the delivery of services under the plan or any other issues related to the plan, 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 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. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.

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

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross
P.O. Box 9086
Oxnard, California 93031-9086

COMPLAINTS

If you have a complaint about services from Anthem, contact Anthem at 1-800-333-0912 or write to Anthem at the address listed below.

Anthem Blue Cross
P.O. Box 9051
Oxnard, California 93031-9051

PART XII NON-DUPLICATION OF ANTHEM BENEFITS

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

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

PART XIII THIRD PARTY LIABILITY

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

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

PART XIV GENERAL PROVISIONS

Benefits Not Transferable: Only eligible Members are entitled to receive benefits under this Agreement. The right to benefits cannot be transferred. FRAUDULENT USE OF SUCH BENEFITS WILL RESULT IN CANCELLATION OF THIS AGREEMENT, AND APPROPRIATE LEGAL ACTION WILL BE TAKEN.

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

1. The Member must be under the care of the Participating Provider at the time of our termination of the provider's participation. The terminated provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.
2. Anthem will furnish such benefits for the continuation of services by a terminated provider only for any of the following conditions:
   a) 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.
   b) A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with the Member and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
   c) 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.
   d) 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.
   e) 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.
   f) 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.
3. Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.
4. Please contact customer service toll free at (800) 333-0912 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

We will notify you by telephone and the provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to negotiate reimbursement and/or contractual requirements that apply to Participating Providers, including payment terms. If the terminated provider does not agree to the same reimbursement and/or contractual

requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuation of care, please refer to the Part entitled "GRIEVANCE PROCEDURES."

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

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

Independent Contractors: The relationship between Anthem and the Medical Group, and between Anthem and Hospitals, is that of an independent contractor. Physicians and other health care professionals within the Medical Group, Hospitals, Skilled Nursing Facilities and other community agencies are not agents or employees of Anthem. Nor is Anthem, or any employee of Anthem, an employee or agent of any Hospital or Medical Group.

Liability of Subscriber to Pay Providers: In accordance with California law, Members will not be required to pay any Participating Provider for amounts owed to that provider by Anthem (other than Copayment/Coinsurance and Deductibles) even in the unlikely event that Anthem fails to pay the provider. Members are liable, however, to pay Non-Participating Providers for any amounts not paid to them by Anthem.

Medical Necessity: The benefits of this Agreement are provided only for services that are Medically Necessary as determined by Anthem. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition, except for routine care and vision care as specifically stated. They must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an inpatient stay is necessary, services are limited to those which could not have been performed before admission.

Member-Provider Relationship: You may refuse to accept procedures or treatments by your Medical Group's Primary Care Physicians. Your Physician may regard this action as incompatible with continuing the Physician/patient relationship and the providing of proper medical care. Physicians use their best efforts to render all necessary and appropriate professional services in a manner compatible with your wishes, and consistent with the Physician's judgment of proper medical practice. If you refuse to follow a recommended treatment or procedure, and the Physician believes that no professionally acceptable alternative exists, you will be advised. If you continue to refuse to follow the recommended treatment or procedure, your coverage will be canceled. Neither the Medical Group, Hospitals, nor any Physician associated with Anthem will have any further responsibility to provide care.

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

Notice of Claim: If the submission of a claim is required to receive benefits under this Agreement, the claim will be allowed only if notice of claim is made to Anthem within fifteen (15) months from the date on which covered expenses were first incurred, unless it is shown that it was not reasonably possible to give notice within that time limit, and that notice was furnished as soon as it was reasonably possible.

Provider Reimbursement: Participating Medical Groups are generally paid a capitation fee, a set and agreed to dollar amount per Member each month, for medical services. Participating Medical Groups may also receive additional reimbursement for certain types of specialty care or for overall efficiency. Hospitals and other health care facilities are paid negotiated fixed fees or on the basis of a negotiated discount from their standard fee-for-service rates.

Providing of Care: Anthem is not responsible for providing any type of Hospital, medical or similar care. Also, Anthem is not responsible for the quality of any type of Hospital, medical or similar care received.

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

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact our customer service department at 1-800-333-0912 for a copy.

Anthem shall neither increase the subscription charges payable by you, nor decrease in any manner the benefits and coverages provided hereunder, except after at least thirty (30) days prior written notice to you.

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

Your Medical Group will provide you notice of termination of a Primary Care Physician to whom you are assigned or from whom you are receiving a course of treatment. To select a new Primary Care Physician, call our Customer Service Department at 1-800-333-0912.

Upon termination of the contract or other agreement with any Participating Provider, Anthem shall be liable to pay the cost of Covered Services (other than applicable Copayment/Coinsurance and Deductibles) rendered by that provider to a Member who retains eligibility under this Agreement, or by operation of law, and who is under the care of that provider at the time of such termination. That provider shall continue to provide such services to the Member, in accordance with the terms of this Agreement, until the services being rendered are completed, unless reasonable and medically appropriate provision is made for the assumption of such services by another provider.

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.

Right of Recovery: When the amount paid by Anthem exceeds the amount for which Anthem is liable under this Agreement, Anthem has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made, or any other plan.

Termination of Providers: Your Medical Group will provide you with a notice of termination of a Primary Care Physician, Medical Group or general acute care Hospital to whom you are assigned or from whom you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To select a new Primary Care Physician, or Medical Group or to locate another Hospital in your area call our customer service department at 1-800-333-0912.

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

OUT OF CALIFORNIA PROVIDERS

The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows our Members to have the reciprocal use of Participating Providers contracting under other states' Blue Cross and/or Blue Shield plans for Medical Emergencies or urgent care. Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. If you have any questions or complaints about the BlueCard Program, please call us at
1-800-333-0912.

If you are traveling outside California and require treatment in connection with a medical emergency or require urgent care, you may use a local Blue Cross and/or Blue Shield Participating Provider under the BlueCard Program. To locate such a local provider, call 1-800-810-BLUE. 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 addition, if you use one of these providers for other than a medical Emergency or for urgent care, there is no benefit under the plan and you will have to pay the entire cost of the services and supplies you receive.

Note: Please refer to the PART entitled YOUR COMPREHENSIVE BENEFITS, subsection Out of Area Emergencies, for information on Follow-Up Care in connection with a medical Emergency or urgent care received outside the state of California.

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 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 ("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. If the Negotiated Price reflects an average expected savings, it 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 the amount you pay 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 statutes mandate Member payment 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 payment for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

PUBLIC POLICY PARTICIPATION

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

PART XV DEFINITIONS

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

Agreement is the Anthem HMO Saver benefit Agreement issued to you by Anthem.

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

Annual Deductible means the amount of charges you must pay for any covered expense for Inpatient Hospital charges (non-Emergency), excluding professional services, outpatient Hospital (non-Emergency) facility charges, Hospice services or Ambulatory Surgical Centers before benefits for such care is available to you under this Agreement.

Anthem Blue Cross (Anthem) is a health care service plan that is regulated by the California Department of Managed Health Care.

Authorization is the approval by your Medical Group of a Referral made by your Primary Care Physician. It is also the approval of your Primary Care Physician or Medical Group in an Emergency.

Coinsurance is the percentage amount indicated in the COPAYMENT/COINSURANCE LIST. It is due and payable by the Member to the Medical Group, Hospital or other provider of care after your Deductible is satisfied.

Complicated Pregnancy means tubal pregnancy, Cesarean section, eclampsia and other conditions directly caused by pregnancy which are considered distinct complications of pregnancy. This does not include elective abortion, false labor, occasional spotting, morning sickness or Physician prescribed rest.

Continued Care is ongoing care which is provided to the Member after the initial medical Emergency services.

Contracting/Preferred Contracting Hospital is a Hospital which has a HMO Saver plan agreement in effect at the time services are rendered.

Copayment is the amount of payment indicated in the COPAYMENT/COINSURANCE LIST. It is due and payable by the Member to the Medical Group, Hospital or other provider of care.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate that is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function, 2) to create a normal appearance, to the extent possible. **Note:** Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons.

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

Creditable coverage means:

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

Custodial Care is care provided primarily to meet the personal needs of the Member. 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 medical personnel.

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

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

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

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

- Blood glucose monitors
- Blood glucose testing strips
- Blood glucose monitors designed to assist the visually impaired
- Insulin pumps and related necessary supplies
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Pen delivery systems for the administration of insulin
- Podiatric devices to prevent or treat diabetes related complications
- Insulin syringes
- Visual aids, excluding eyewear to assist the visually impaired with proper dosing of insulin