Anthem BlueCross

Dear Anthem Blue Cross Life and Health Insurance Company Insured,

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

This booklet describes the benefits of your coverage and various limitations, exclusions and conditions on those benefits. It is important for you to read this booklet carefully and understand it so that you will have an idea of what is not covered and the terms and limitations of your coverage.

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

If you have any questions regarding your eligibility or membership, please feel free to contact our customer service department toll free at (800) 627-8797 or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA 93031-9062.

If you have any questions regarding claims status or your benefits under this Certificate, please feel free to contact our customer service department toll free at (800) 627-8797, or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 60007, Los Angeles, CA 90060-0007.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

Kathy Kiefer
Secretary
Anthem Blue Cross Life and Health Insurance Company

07-01-2012

HOW TO CONTACT US

Our web site **(www.anthem.com)** 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
- Review your health plan's benefits
- Check status of your claims and download claim forms
- Learn about Pharmacy benefits
- Find out about health programs offered by your plan
- Access premium health content and tools from Subimo™ and WebMD®.

If you want secure access to all features the web site has to offer, simply log on to **www.anthem.com**, 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…	Phone Number	Address
Enrollment and Membership	(800) 627-8797	Anthem Blue Cross Life and Health Insurance Company P.O. Box 9062 Oxnard, CA 93031-9062
Medical Claims and Benefits	(800) 627-8797	Anthem Blue Cross Life and Health Insurance Company P.O. Box 60007 Los Angeles, CA 90060-0007
Participating Providers in California	(800) 627-8797	www.anthem.com
Providers outside California (Out-of-Area Services)	(800) 810-BLUE (2583)	www.bcbs.com
Hearing and Speech Impaired Customer Service	TDY (800) 735-2929	Anthem Blue Cross Life and Health Insurance Company P.O. Box 9062 Oxnard, CA 93031-9062
Preservice Review	(800) 274-7767	
Pharmacy – Retail	(800) 627-8797	Pharmacy Benefits Manager Prescription Drug Program Commercial Claims P.O. Box 2872 Clinton, IA 52733-2872 www.anthem.com
Pharmacy – Home Delivery	(866) 297-1013	Pharmacy Benefits Manager Home Delivery Program P.O. Box 66558 St. Louis, MO 63166-6558 www.anthem.com

IMPORTANT INFORMATION

At the back of your Certificate there are mandated notices required by either state or federal law, including information on Language Assistance.

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INTRODUCTION

Notice to Buyer: This is a limited-benefit Certificate

This Certificate is not designed to be a comprehensive medical or major medical Certificate. The benefits provided by this plan are limited, and may not cover all your medical expenses. You may have to pay substantial amounts of your own money for medical expenses, even if your illness is serious.

Anthem Blue Cross Life and Health Insurance Company ("Anthem Blue Cross Life and Health," or "Anthem") has a Group Insurance Policy (the "Policy") with your Employer (Group). The benefits of this Certificate are provided while Medically Necessary for the Certificateholder and enrolled Dependents for a covered illness, injury or condition, subject to all of the terms and conditions of the Policy.

The Certificate is a summary and the Policy contains the exact terms and conditions of coverage. Please read the disclosure and the Certificate 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 CERTIFICATE PRIOR TO ENROLLMENT.

You also have the right to receive a copy of the Notice of Privacy Practices. You may obtain the document by calling our customer service department toll free at (800) 627-8797 or by accessing our web site at **www.anthem.com**.

Covered Expense for Participating Providers is based on the Maximum Allowed Amount. Participating Providers have a Prudent Buyer Plan Participating Provider agreement in effect with us and have agreed to accept the Maximum Allowed Amount as payment in full. Utilizing Participating Providers will enable you to maximize your plan benefits and minimize out-of-pocket expenses. Non-Participating Providers do not have a Prudent Buyer Plan Participating Provider agreement with us. Your personal financial costs when using Non-Participating Providers may be considerably higher than when you use Participating Providers. You will be responsible for any balance of a Non-Participating Provider's bill which is above the Maximum Allowed Amount payable for Non-Participating Providers under this Certificate. Please read the benefit sections carefully to determine the differences in costs. See the Part entitled "DEFINITIONS" for more information about the types of providers.

While it is your responsibility to determine if the provider you choose is a Participating Provider, our customer service representatives can also assist you with the selection of a Participating Provider in your area. A Participating Provider Directory, or information on Participating Providers, may be obtained by calling our customer service department toll free at (800) 627-8797 or by accessing our web site at **www.anthem.com**. Click on 'Provider Finder' and follow the directions to find a Participating Provider in your area. The Participating Provider Directory is updated quarterly and lists providers that have a Prudent Buyer Plan Participating Provider agreement in effect with us. Working together as partners in your health care can make your medical experiences less stressful and more cost-effective to you.

The provisions of this Certificate apply in the same manner for Covered Services that are received both in and out of California, including Covered Services received by Dependents who live outside California and away from the principal residence of the Certificateholder. **Please see the section entitled "Out-of-Area Services" under the Part entitled "GENERAL PROVISIONS" for an explanation of the BlueCard program, which allows the use of BlueCard participating providers outside California.** Also, please see the section entitled "Complaints" under the Part entitled "BINDING ARBITRATION" for information about complaints regarding your ability to access needed care in a timely manner.

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals and other health care facilities may be paid a fixed fee, or they may be paid on a discounted fee-for-service basis. For additional information, you may contact us toll free at (800) 627-8797, or you may contact your Participating Provider.

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

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

You should obtain more information before you become a Certificateholder or select a network provider. Call your prospective doctor or clinic, or call customer service toll free at (800) 627-8797 to ensure that you can obtain the health care services that you need.

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

The benefits of this Certificate are provided only for those services that are considered Medically Necessary and a Covered Service. If you have any question as to whether a service is covered, consult this Certificate or call us toll free at (800) 627-8797. Our customer service representatives can assist you in determining the benefits of your plan and, if necessary, help you obtain Preservice Review for the types of benefits that require Preservice Review.

CHOICE OF HOSPITAL, SKILLED NURSING FACILITY AND ATTENDING PHYSICIAN: Nothing contained in this Certificate restricts or interferes with your right to select the Hospital, Skilled Nursing Facility or attending Physician of your choice. However, your choice may affect the benefits payable according to this plan.

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 our customer service department toll free at (800) 627-8797. Please refer to "Continuation of Care after Termination of Provider" in the Part entitled "GENERAL PROVISIONS."

In addition, Transition Assistance is available to provide for continuity of care for new Insureds receiving services from a Non-Participating Provider. Please see "Transition Assistance for New Insureds" under the Part entitled "GENERAL PROVISIONS."

Throughout this Certificate, you will find key terms which appear with the first letter of each word capitalized. When you see these capitalized words you should refer to the Part of this Certificate 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.

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

PART I WHO IS COVERED AND WHEN

A. ELIGIBILITY

1. Certificateholder's Eligibility

a. The person eligible to enroll as a Certificateholder is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Employer, with a normal work week of at least thirty (30) hours, at the Employer's regular place of business, and who has met any applicable waiting period requirements.

b. Sole proprietors, partners of a partnership, and corporate officers are also eligible to enroll as Certificateholders if they are actively engaged on a full-time basis, work at least twenty (20) hours a week in the Employer's business, and are included as employees under a health care plan contract of the Employer.

c. Permanent part-time employees who work at least twenty (20), but not more than twenty-nine (29), hours per week are deemed to be eligible employees if all four (4) of the following apply:

   i. They otherwise meet the definition of an eligible employee except for the number of hours worked.
   ii. The Employer offers the employees health coverage under a health benefit plan.
   iii. All similarly situated individuals are offered coverage under the health benefit plan.
   iv. The employee must have worked at least twenty (20) hours per normal work week for at least fifty percent (50%) of the weeks in the previous calendar quarter.

   Note: This applies only if your Employer elects to offer coverage to part-time employees and has notified us accordingly. Additional part-time eligibility is available to part-time employees who work fifteen (15) to nineteen (19) hours per week only if this option is selected by the Group.

d. The employees must be in an enrollment class for which the Group makes application to us and which we accept.

e. An eligible person may apply for coverage as a Certificateholder within thirty one (31) days before the first day of the month following the completion of the waiting period chosen by the Group and agreed to by Anthem Blue Cross Life and Health. The waiting period is indicated on the Employer application.

2. Dependent's Eligibility

The following persons are eligible to apply for coverage as Dependents of the Certificateholder: (a) either the Certificateholder's Spouse or Domestic Partner, and (b) a Child of the Certificateholder, Spouse or Domestic Partner. Coverage will be provided equally to a Spouse or Domestic Partner including children of a Spouse or Domestic Partner, providing eligibility requirements are met. The Effective Date will be determined by us. For information on Effective Dates, please see section D., "Effective Dates."

Definition of Dependent

a. **Spouse** is the Certificateholder's Spouse under a legally valid marriage. Spouse does not include any person who is covered as a Certificateholder or Domestic Partner.

b. **Domestic Partner** is the Certificateholder's Domestic Partner, subject to the following:

The Certificateholder and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created, and the Domestic Partnership has not terminated.

Domestic Partner does not include any person who is covered as a Certificateholder or Spouse.

c. **Child** is the Certificateholder's, Spouse's or Domestic Partner's natural Child, stepchild, legally adopted Child, or Child for whom the Certificateholder, Spouse or Domestic Partner has been appointed permanent legal guardian by a final court decree or order, subject to the following:

i. Children of the Certificateholder, the Certificateholder's enrolled Spouse, or the Certificateholder's enrolled Domestic Partner are eligible to the twenty-sixth (26^{th}) birthday regardless of the marital status of such Child and regardless of:

- the Child's financial dependency on the Certificateholder or on any other person;
- the Child's residency with the Certificateholder or with any other person;
- the Child's status as a student;
- the Child's employment; or
- any combination of the above factors.

ii. Newborns of the Certificateholder, the Certificateholder's enrolled Spouse, or the Certificateholder's enrolled Domestic Partner are automatically enrolled for the first thirty-one (31) days of life only. WE MUST RECEIVE, WITHIN THIRTY-ONE (31) DAYS OF THE NEWBORN'S BIRTH, AN APPLICATION TO CONTINUE ENROLLMENT OF THE NEWBORN (AS DESCRIBED IN SECTION B,. "APPLICATION FOR ENROLLMENT") AND ANY ADDITIONAL PREMIUM DUE, OR COVERAGE WILL END AFTER THIRTY-ONE (31) DAYS.

NEWBORNS OF THE CERTIFICATEHOLDER'S DEPENDENT CHILDREN ARE **NOT** COVERED UNDER THE POLICY.

iii. A Child who is in the process of being adopted is considered a legally adopted Child if we receive legal evidence of both: (1) the intent to adopt, and; (2) that the Certificateholder, Spouse or Domestic Partner has either: (a) the right to control the health care of the Child, or; (b) assumed a legal obligation for full or partial financial responsibility for the Child in anticipation of the Child's adoption.

Legal evidence to control the health care of the Child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the Child's birth parent or other appropriate authority or, in the absence of a written document, other evidence of the Certificateholder's, Spouse's or Domestic Partner's right to control the health care of the Child.

iv. A Child for whom the Certificateholder, Spouse or Domestic Partner has been appointed permanent legal guardian, provided we have received proper court documentation in the form of "Letters of Guardianship," showing filed date and county court seal.

v. Unmarried children of the Certificateholder, the Certificateholder's enrolled Spouse, or the Certificateholder's enrolled Domestic Partner from the twenty-sixth (26^{th}) birthday and older, if the Child is:
   - Covered under this plan or was covered under a prior plan immediately before being covered under this plan, and
   - Incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and
   - At least one-half dependent on the Certificateholder for support and maintenance.

   A Physician must certify this physically or mentally disabling injury, illness or condition in writing.

   We will notify the Certificateholder that the dependent Child's coverage will terminate upon attainment of the limiting age of twenty-six (26) unless the Certificateholder submits proof of the criteria described above within sixty (60) days of the date of receipt of the notification. We will send this notification to the Certificateholder at least ninety (90) days before the Child attains the limiting age. Upon receipt of a request by the Certificateholder for continued coverage of the Child and proof of the criteria described above, we will determine whether the Child meets that criteria before the date the Child attains the limiting age. If we fail to make the determination by that date, coverage for the Child shall be continued pending our determination. After two (2) years of continued enrollment after attaining the limiting age, we may request proof of continuing dependency and that a physically or mentally disabling injury, illness or condition still exists, but not more often than yearly.

   For a dependent unmarried Child from the twenty-sixth (26^{th}) birthday and older who is replacing other prior coverage with Anthem Blue Cross Life and Health coverage, we will request information that the Child meets the criteria for coverage as described above. The Certificateholder must submit the information within sixty (60) days of receiving the request. We will determine whether the Child meets the criteria for continued coverage. We may request information about the dependent Child initially and not more frequently than annually thereafter to determine if the Child continues to satisfy the criteria described above.

Note: See section D., "Effective Dates," for more information on how to apply for, add or continue coverage for Dependents.

Note: Dependents of the children of the Certificateholder, the Certificateholder's enrolled Spouse, or the Certificateholder's enrolled Domestic Partner are **not** covered under the Policy.

B. **APPLICATION FOR ENROLLMENT**

Note: Applications for enrollment, including applications for those declining coverage, **must** be submitted and received prior to the Effective Date. An application must be approved by us in order for coverage to come into effect.

Note: Premiums may change when Dependents are enrolled in or removed from coverage.

1. **Filing of Applications**

   a. Every person eligible to enroll as a Certificateholder must file an application with the Employer within a time period of thirty-one (31) days after becoming eligible for coverage. This application must include any eligible Dependents for whom application is being filed.

   b. The Certificateholder must file an application with the Employer to enroll a new Spouse or a new Domestic Partner within a time period ending thirty-one (31) days after marriage or a registered Domestic Partnership.

   c. The Certificateholder must file an application with the Employer to continue enrollment of a newly acquired Child within a time period ending thirty-one (31) days after the birth or acquisition of the Child, or final court decree or order of permanent legal guardianship.

   d. If the person eligible to enroll as a Certificateholder does not elect to be covered, or does not elect coverage for his or her Spouse, Domestic Partner or children, under the Policy, the person eligible to enroll as a Certificateholder and his or her Spouse or Domestic Partner and children may have to wait up to twelve (12) months from any future election of coverage for another opportunity to obtain such coverage. However, in certain circumstances, as described under section C., "Special Enrollment Periods," this twelve (12) month period may not apply.

2. The Employer is responsible for forwarding all enrollment applications to us and for notifying us of any change in the Certificateholder's place of residence.

3. If the number of Certificateholders falls below the Anthem Blue Cross Life and Health specified guidelines of such eligible persons, we may cancel the Policy.

C. **SPECIAL ENROLLMENT PERIODS.** An individual otherwise eligible to enroll except for a failure to enroll on time may enroll without waiting twelve (12) months if any one of the circumstances set forth below applies:

1. The individual meets all of the following requirements:

   a. He or she was covered under another employer health benefit plan, the Healthy Families Program, the California Access for Infants and Mothers (AIM) Program, or Medi-Cal at the time he or she was first eligible to enroll.

b. He or she, or the Certificateholder on behalf of an eligible dependent, certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, the California Access for Infants and Mothers Program (AIM), or Medi-Cal was the reason for declining enrollment, provided that, the individual covered under the other employer health benefit plan, the Healthy Families Program, the AIM program or Medi-Cal or the Certificateholder on behalf of an eligible dependent, was given the opportunity to make this certification and was notified that failure to do so could result in later treatment as a late enrollee.

c. He or she has lost or will lose coverage under the other employer health benefit plan as a result of: termination of employment or change in employment status of the individual or the person through whom the individual was covered as a dependent; termination of the other plan's coverage; cessation of an employer's contribution toward an employee's or dependent's coverage; death of, or legal separation or divorce from, the person through whom the individual was covered as a dependent, or loss of coverage under the Healthy Families Program, the California Access for Infants and Mothers Program or Medi-Cal.

d. He or she requests enrollment by filing an application within thirty-one (31) days after termination of coverage or termination of employer contribution toward coverage, provided under another employer health benefit plan. This does not apply to Healthy Families, the AIM Program or Medi-Cal coverage; please see items 7. and 8. in this section for additional information.

2. The Group offers multiple health benefit plans and the Certificateholder elects a different plan during an open enrollment period.

3. A court has ordered coverage be provided for a Spouse or minor Child under your employee health benefit plan. We must receive a copy of the court order, or receive a request from the district attorney, either parent or the person having custody of the Child, the Employer, or Group administrator. An application must be filed within thirty-one (31) days from the date the court order is issued.

4. A court has ordered coverage be provided under your employee health benefit plan for an unmarried dependent Child who has attained the limiting age, if the dependent Child is incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition, and is at least one-half dependent on the Certificateholder for support and maintenance. A Physician must certify this physically or mentally disabling injury, illness or condition in writing.

   Anthem Blue Cross Life and Health will request information that the Child meets the criteria for coverage as described above. The Certificateholder must submit the information within sixty (60) days of receiving the request. We will determine whether the Child meets the criteria for continued coverage. We may request information about the dependent Child initially and not more frequently than annually thereafter to determine if the Child continues to satisfy the criteria described above.

We must receive a copy of the court order, or receive a request from the district attorney, either parent or the person having custody of the Child, the Employer, or group administrator. An application must be filed within thirty-one (31) days from the date the court order is issued.

5. In the case of an eligible employee, we cannot produce a written statement from the Group stating that the eligible employee, prior to declining coverage was provided with and signed acknowledgment of an explicit written notice in bold face type specifying that failure to elect coverage during the initial enrollment period permits us to impose, at the time of a later decision to elect coverage, an exclusion from coverage for a period of twelve (12) months as well as a six (6) month Preexisting Condition exclusion, unless the individual meets the criteria specified in items 1., 2., 3., or 4. above.

6. The individual meets the criteria described in paragraph 1. of this section C. and was under a COBRA or Cal-COBRA continuation provision and the coverage under that provision has been exhausted.

7. The individual, who is an eligible employee, or his or her dependent, was covered under Medi-Cal, Healthy Families, or the California Access for Infants and Mothers Program and that coverage ended because of loss of eligibility. An application must be filed within sixty (60) days after the date that coverage ended.

8. The individual, who is an eligible employee, or his or her dependent, while covered under Medi-Cal or Healthy Families, becomes eligible for state premium assistance, with respect to coverage under this plan. An application must be filed within sixty (60) days after the date eligibility for assistance has been determined.

9. The individual (a) is an eligible employee who previously declined coverage as a Certificateholder under the Policy, (b) has subsequently acquired a dependent who would be eligible for coverage as a dependent through marriage, birth, adoption, or placement for adoption, and (c) enrolls for coverage under the Policy on his or her behalf, and on behalf of his or her dependent, within thirty-one (31) days following the date of marriage, birth, adoption, or placement for adoption.

10. The individual is an eligible employee who has previously declined coverage under the Policy for himself or herself, or for his or her dependents during a previous enrollment period because he or she, or his or her dependents, were covered by another employer health benefit plan at the time of the previous enrollment period. That individual may enroll himself or herself, or his or her dependents, for coverage under the plan during a special open enrollment opportunity if he or she, or his or her dependents, have lost or will lose coverage under the other employer health benefit plan. You must request the special open enrollment opportunity not more than thirty-one (31) days after the date the other health coverage is exhausted or terminated.

D. EFFECTIVE DATES

If the Employer pays the premiums required for an eligible person to us when they are due, the Effective Date of coverage for that person is as follows:

1. Certificateholder's Effective Date

a. For a person who files an application to enroll as a Certificateholder within the time limits stated under section B., "Application for Enrollment," coverage begins on the first of the month following our underwriting approval.

"takeover" exception:

For a person who is enrolled as a Certificateholder on the Employer Effective Date and who, immediately prior to that date, was covered under the Employer's health plan which is replaced by the Policy, coverage begins on the Employer Effective Date. Any waiting period related to a Preexisting Condition will be reduced by the number of months the Certificateholder was covered without interruption under the Group's prior health plan.

b. For a person who does not file an application to enroll as a Certificateholder within the time limits stated under section B., "Application for Enrollment," coverage will be deferred for a period of twelve (12) months from any future election of coverage.

c. Effective Dates for certain Special Enrollment Periods:

i. If the Certificateholder may enroll without waiting under the terms described in section C., "Special Enrollment Periods," paragraph 9., the Effective Date of the Certificateholder's coverage shall be the first day of the month following the date we receive the completed application for enrollment in the case of marriage, or the date of birth, or the date of adoption or placement for adoption, whichever applies.

ii. If the Certificateholder may enroll without waiting under the terms described in section C ., "Special Enrollment Periods," paragraph 10., upon enrollment, coverage shall be effective not later than the first day of the first month beginning after the date we receive the application for enrollment.

COVERAGE ONLY FOR CERTIFICATEHOLDERS:

We will provide coverage only for Certificateholders.

2. Dependent's Effective Date

a. If the application of a person enrolling as a Certificateholder includes application for an eligible Spouse, Domestic Partner or Child, coverage for that Spouse, Domestic Partner or Child begins on the Certificateholder's Effective Date.

b. For a new Spouse or a new Domestic Partner of a Certificateholder who is already enrolled under the Policy, coverage begins on the first day of the month following marriage or a registered Domestic Partnership, but only if we receive, within thirty-one (31) days of the marriage or registration, an application to enroll the Spouse or Domestic Partner and any additional premium due.

c. A Child born (newborn) to a Certificateholder, Spouse or Domestic Partner who is already enrolled under the Policy, will be automatically enrolled for the first thirty-one (31) days of life only. We must receive, within thirty-one (31) days of the Child's birth, an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due, or coverage will end after thirty-one (31) days.

d. A newly acquired Child (except a newborn) of a Certificateholder, Spouse or Domestic Partner who is already enrolled under the Policy will be automatically enrolled for a period of thirty-one (31) days only beginning on the date of adoption, or placement for adoption, of the Child. We must receive, within thirty-one (31) days of acquiring the Child, an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due, or coverage will end after thirty-one (31) days.

e. A newly acquired Child (except a newborn) of a Certificateholder, Spouse or Domestic Partner who is the permanent legal guardian and already enrolled under the Policy will be automatically enrolled for a period of thirty-one (31) days only, beginning on the date of the final court decree or order of legal guardianship. We must receive, within thirty-one (31) days of issuance of the final court decree or order of legal guardianship, an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due, or coverage will end after thirty-one (31) days.

"takeover" exception:

If the Spouse, Domestic Partner or Child is enrolled on the Employer Effective Date and if, immediately prior to that date, he or she was covered under the Employer's health plan which is replaced by the Policy, then coverage begins on the Employer Effective Date. (Under these "takeover" circumstances, the Spouse's, Domestic Partner's or Child's Effective Date is not subject to the terms outlined under COVERAGE FOR SPOUSES, DOMESTIC PARTNERS AND CHILDREN ONLY OF CERTIFICATEHOLDERS, though the effective date of any increase in benefits is.) Any waiting period related to a Preexisting Condition will be reduced by the number of months the Insured was covered without interruption under the Group's prior health plan.

f. For a Spouse, Domestic Partner or Child for whom the Certificateholder does not file an application within the time limits stated under section B., "Application for Enrollment," coverage begins on the first day of the month following our underwriting approval.

g. If the Certificateholder may enroll his or her Dependents without waiting under the terms described in section C., "Special Enrollment Periods" paragraph 10., upon enrollment, coverage shall be effective not later than the first day of the first month beginning after the date we receive the application for enrollment.

COVERAGE FOR SPOUSES, DOMESTIC PARTNERS AND CHILDREN ONLY OF CERTIFICATEHOLDERS:

We will provide coverage for the Spouses, Domestic Partners and children of Certificateholders. If, at the time a Certificateholder's coverage or an increase in benefits would begin, the Certificateholder is not an eligible employee of the Employer, we will not provide coverage for the Certificateholder's Spouse, Domestic Partner or children. However, if the Certificateholder subsequently does become such an eligible employee of the Employer, we will begin coverage for the Certificateholder's Spouse, Domestic Partner and children effective the first day of the month following receipt of information from the Employer that the Certificateholder meets the eligibility requirements.

E. LEAVE OF ABSENCE

1. Temporary Personal Leave of Absence

Enrolled Certificateholders are eligible to continue Group coverage for themselves and their enrolled Dependents for a maximum period as elected by the Employer on the Employer application, but in no event more than three (3) months, provided that the Certificateholder continues on an Employer approved personal leave of absence and the Employer continues to pay the required monthly premiums.

2. Temporary Medical Leave of Absence

Enrolled Certificateholders are eligible to continue Group coverage for themselves and their enrolled Dependents for a maximum period as elected by the Employer on the Employer application, but in no event more than six (6) months, provided that the Certificateholder continues an Employer approved medical leave of absence and the Employer continues to pay the required monthly premiums.

Note: Continuation for items 1. and 2. above will occur only following receipt by us of written request to continue coverage within thirty (30) days of the event. Notification within thirty (30) days of the event is required when the leave of absence begins or ends.

3. Temporary Military Leave of Absence

Enrolled Certificateholders who are 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 at (800) 627-8797 for information on how to apply for reinstatement of coverage following active duty as a reservist.

Note: Notification within thirty (30) days of the event is required when the leave of absence begins or ends.

Any leave of absence, continuation of coverage and/or reinstatement is subject to all of the other terms, conditions and limitations of the Policy.

If an Insured becomes Totally Disabled please refer to the Part entitled "EXTENSION OF BENEFITS."

F. **WHEN YOUR COVERAGE ENDS**

We are not required to send a notice to the Insured when coverage ends. We will notify the Group, and the Group will be responsible for notifying the Insured of any cancellation or other termination of coverage.

An Insured's coverage ends under the following conditions:

1. **Certificateholder**

a. On the date the Policy between the Group and Anthem Blue Cross Life and Health Insurance Company is terminated, or

b. On the next premium due date after the Certificateholder no longer meets the eligibility requirements established by the Group and Anthem Blue Cross Life and Health Insurance Company, or

c. On the next premium due date after we receive from the Group or the Certificateholder written notice of the Certificateholder's voluntary cancellation of coverage, or

d. On the first of the month following the month the Certificateholder is no longer considered an eligible employee or ceases to be a member of a Guaranteed Association (but only if coverage is terminated without regard to any health status-related factor), or

e. At the end of the three (3) month period for a personal leave of absence unless the Certificateholder returns to active employment, or

f. At the end of the six (6) month period for a medical leave of absence unless the Certificateholder returns to active employment, or

g. At the end of the period for a military leave of absence for Insureds who terminated coverage as a result of being ordered to active duty on or after January 1, 2007 unless the Certificateholder returns to active employment, or.

h. When the required premiums are not paid, Anthem Blue Cross Life and Health may terminate the Group's coverage upon first mailing a written Notice of Cancellation to the Group at least thirty (30) days, or if longer, the period required by federal law, prior to that termination. The coverage will end as of 12:00 midnight on the thirtieth (30^{th}) day after the date on which the Notice of Cancellation is sent. The Notice of Cancellation shall state that the Policy shall not be terminated if the Group makes appropriate payment in full within thirty (30) days after Anthem Blue Cross Life and Health issues the Notice of Cancellation. If payment is not received within thirty (30) days of issuance, the Policy will be cancelled for non-payment of premiums and Anthem Blue Cross Life and Health will send a notice to the Group confirming that the Policy has been cancelled. The Notice of Cancellation shall also state that, if the Policy is terminated for nonpayment and the Group wishes to apply for reinstatement, the Group will be required to submit a new application for coverage and will be required to submit any premiums that are owed, in addition to a $50 reinstatement fee and any other administrative fee payable. Reinstatement is not guaranteed, and the Group's request for reinstatement may be declined.

2. **Spouse**

   a. On the date the Certificateholder's coverage is canceled or terminated, or

   b. On the next premium due date after final decree of divorce, annulment or dissolution of marriage.

3. **Domestic Partnership**

   a. On the date the Certificateholder's coverage is canceled or terminated, or

   b. On the next premium due date after the Domestic Partner no longer satisfies all eligibility requirements specified for Domestic Partners.

4. **Child**

   a. On the date the Certificateholder's coverage is canceled, or

   b. On the next premium due date after the Child reaches age twenty-six (26), or on the date permanent legal guardianship ends, or

   c. On the next premium due date after the Child reaches the limiting age of twenty-six (26) unless the unmarried Child is, upon reaching the limiting age, at least one-half dependent upon the Certificateholder for support and maintenance, and is incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition. A Physician must certify this disability in writing. Anthem Blue Cross Life and Health will notify the Certificateholder that the dependent Child's coverage will terminate upon attainment of the limiting age unless the Certificateholder submits proof of the criteria described above within sixty (60) days of the date of receipt of notification. We will send this notification to the Certificateholder at least ninety (90) days before the Child attains the limiting age. Upon receipt of a request by the Certificateholder for continued coverage of the Child and proof of the criteria described above, we will determine whether the Child meets that criteria before the date the Child attains the limiting age. If we fail to make the determination by that date, coverage for the Child shall be continued pending our determination. After two (2) years of continued enrollment after attaining the limiting age, we may request proof of continuing dependency and that a physically or mentally disabling injury, illness or condition still exists, but not more often than yearly, or

   d. For a Child born (newborn) to a Certificateholder, Spouse or Domestic Partner who is already enrolled under the Policy, coverage ends on the day following the thirty-first (31st) day of life if we do not receive an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due.

   e. For a newly acquired Child (except a newborn) of a Certificateholder, Spouse or Domestic Partner who is already enrolled under the Policy, coverage ends on the day following the thirty-first (31^{st}) day from the date of adoption, or placement for adoption, of the Child if we do not receive an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due.

f. For a newly acquired Child (except a newborn) of a Certificateholder, Spouse or Domestic Partner who is the permanent legal guardian and already enrolled under the Policy, coverage ends on the day following the thirty-first (31st) day from the date of the final court decree or order of legal guardianship if we do not receive an application to continue enrollment of the Child (as described in section B., "Application for Enrollment") and any additional premium due.

5. **Any Insured**

a. When any misrepresentation is discovered on an application or health statement, or

b. When an act of fraud associated with this coverage has been committed, or

c. When an Insured resides in a foreign country for more than six (6) consecutive months and does not work in the plan's service area.

Note: The Group is responsible for notifying us of all changes affecting the Certificateholder's place of residence.

Improper cancellation or non-renewal (requests for review)
If you believe that your coverage has been improperly canceled or not renewed, you may request a review of the matter by the California Department of Insurance (CDI).

G. RENEWAL PROVISIONS

Anthem Blue Cross Life and Health will provide benefits under the Policy for as long as it is in effect. The Policy remains in effect subject to Anthem Blue Cross Life and Health's right to terminate, decline to renew or amend the Policy, or to change premium charges. Anthem Blue Cross Life and Health may amend the Policy or, to the extent permitted by law, change premium charges upon sixty (60) days prior written notice to your Employer. Anthem Blue Cross Life and Health will not increase the premium charges payable by your Employer or decrease benefits and coverage except after at least sixty (60) days prior written notice to your Employer.

PART II ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS

The benefits described throughout this Part II are provided for Covered Expense incurred for treatment of a covered illness, injury or condition. These benefits are subject to all provisions of the Policy, which may limit benefits or result in benefits not being payable. Any limits on the number of visits or days covered are stated under the specific benefit or under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

ANNUAL DEDUCTIBLES

All Covered Services are subject to annual Deductibles except as specifically stated in this Certificate. We will not pay for any medical benefits until the applicable annual Deductibles are satisfied each Year. There are certain exceptions where we will pay for medical benefits before the annual Deductibles are met. These exceptions are specifically set out in this Certificate.

Deductible amounts for Participating Providers and Non-Participating Providers accumulate separately each Year, as follows:

- **Participating Provider Deductible**:
  - **Individual: $1,500** per Year for a single Insured enrolled in a Certificateholder only contract.
  - **Family: $3,000** per Year for a Family Contract, which is satisfied when two or more Insured's eligible Covered Expense collectively meet this aggregate amount.

  Once your Deductible for Participating Provider services has been satisfied, no further Deductible for Participating Providers will be required for the remainder of that Year.

- **Non-Participating Provider Deductible**:
  - **Individual: $3,000** per Year for a single Insured enrolled in a Certificateholder only contract.
  - **Family: $6,000** per Year for a Family Contract, which is satisfied when two or more Insureds' eligible Covered Expense collectively meet this aggregate amount.

  Once your Deductible for Non-Participating Provider services has been satisfied no further Deductible for Non-Participating Providers will be required for the remainder of that Year.

Note: Under a Family Contract, when an Insured satisfies the individual Deductible amount, no further Deductible is required for that Insured for the remainder of that calendar Year; however, an Insured may not contribute an amount greater than the individual Deductible toward the family Deductible.

During each Year, each Insured is responsible for all Covered Expense incurred for Covered Services up to the applicable Deductible amounts, as stated above, have been met. These Deductible amounts must be recorded in our files as payable by the Insured to the provider of service. A claim must be submitted in order for us to record your eligible covered Deductible expense. We will record your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply.

If you submit a claim for services which have a maximum payment limit and your Deductible has not been satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible amount.

Certain Covered Services have maximum visit and/or day limits per Year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

Note: Payments you make for Covered Services apply toward your annual Deductible except for those listed below. "Copayment" in this list refers to the fixed dollar amount (for example, for Infertility services, it is the $500 Copayment).

- Coinsurance for Office Visits (Participating Providers only)
- Coinsurance for Online Visits (Participating Providers only)
- Coinsurance for Retail Health Clinic visits (Participating Providers only)
- Emergency room Copayment
- Copayment for not obtaining Preservice Review
- Copayment for Infertility services
- Amounts you pay for Prescription Drugs under the Part entitled "YOUR GENERIC PRESCRIPTION DRUG BENEFITS"

Note: The benefits listed below are not subject to the annual Deductible when Covered Services are received from Participating Providers:

- Office Visits
- Online Visits
- Retail Health Clinic Visits
- Preventive Care
- Hospice Care

The Participating Provider Deductible and Non-Participating Provider Deductible amounts are applied respectively to the Insured's Participating Provider out-of-pocket maximum and Non-Participating Provider out-of-pocket maximum, as explained under the section in this Part entitled "Annual Out-of-Pocket Maximums."

Once the Participating Deductible has been met, charges for Covered Services received from a Participating Provider will apply only to the Participating Provider Annual Out-of-Pocket Maximum. Once the Non-Participating Deductible has been met, charges for Covered Services received from a Non-Participating Provider will apply only to the Non-Participating Provider Annual Out-of-Pocket Maximum. Please see the section in this Part entitled "Annual Out-of-Pocket Maximums."

MAXIMUM ALLOWED AMOUNT

General

This section describes the term "Maximum Allowed Amount" as used in this Certificate, and what the term means to you when obtaining Covered Services under your plan. The Maximum Allowed Amount is the total reimbursement payable under your plan for Covered Services you receive from Participating Providers, Non-Participating Providers and Other Eligible Providers. It is our payment towards the services billed by your provider combined with any Deductible, Copayment or Coinsurance owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under your plan, then you could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from a Non-Participating Provider or Other Eligible Provider, you may be billed by the provider for the difference between their charges and our Maximum Allowed Amount. In many situations, this difference could be significant.

We have provided two examples, below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The plan has an Insured Coinsurance cost share of 30% for Participating Provider services after the Deductible has been met.

- The Insured receives services from a Participating surgeon. The charge is $2,000. The Maximum Allowed Amount under the plan for the surgery is $1,000. The Insured's Coinsurance responsibility when a Participating surgeon is used is 30% of $1,000, or $300. This is what the Insured pays. We pay 70% of $1,000, or $700. The Participating surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has an Insured Coinsurance cost share of 50% for Non-Participating Provider services after the Deductible has been met.

- The Insured receives services from a Non-Participating surgeon. The charge is $2,000. The Maximum Allowed Amount under the plan for the surgery is $1,000. The Insured's Coinsurance responsibility when a Non-Participating surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the Non-Participating surgeon could bill the Insured the difference between $2,000 and $1,000, so the Insured's total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

When you receive Covered Services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is one single code that includes all of the procedures performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider, Non-Participating Provider or Other Eligible Provider.

Participating Providers: For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for your plan is the rate the provider has agreed with Anthem Blue Cross Life and Health to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call customer service toll free at (800) 627-8797 for help in finding a Participating Provider or visit **www.anthem.com**.

Non-Participating Providers and Other Eligible Providers: Providers who are not in our Prudent Buyer network are Non-Participating Providers or Other Eligible Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For Covered Services you receive from a Non-Participating Provider or Other Eligible Provider, the Maximum Allowed Amount will be based on the applicable Anthem Blue Cross Life and Health Non-Participating Provider or Other Eligible Provider rate or fee schedule for your plan, an amount negotiated by us or a third party vendor which has been agreed to by the Non-Participating Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Non-Participating Provider or Other Eligible Provider, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem Blue Cross Life and Health will update such information, which is unadjusted for geographic locality, no less than annually.

Unlike Participating Providers, Non-Participating Providers and Other Eligible Providers may send you a bill and collect for the amount of the Non-Participating Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this plan. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call customer service toll free at (800) 627-8797 for help in finding a Participating Provider or visit our website at **www.anthem.com**. Customer service is also available to assist you in determining your plan's Maximum Allowed Amount for a particular Covered Service from a Non-Participating Provider or Other Eligible Provider.

Please see the "Out-of-Area Services" section in the Part entitled "GENERAL PROVISIONS" for additional information.

Please see the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS -WHAT IS COVERED" for your payment responsibility.

Insured Cost Share

For certain Covered Services, and depending on your plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductible, Copayment, and/or Coinsurance). Your cost share amount and out-of-pocket limits may be different depending on whether you received Covered Services from a Participating Provider, Non-Participating Provider or Other Eligible Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Non-Participating Providers or Other Eligible Providers. Please see the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED" in this Certificate for your cost share responsibilities and limitations, or call customer service toll free at (800) 627-8797 to learn how this plan's benefits or cost share amounts may vary by the type of provider you use.

Anthem Blue Cross Life and Health will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your provider for non-Covered Services, regardless of whether such services are performed by a Participating Provider, Non-Participating Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower Participating Provider cost share percentage when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital or facility, you will pay the Participating Provider cost share percentage of the Maximum Allowed Amount for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Referrals

In some circumstances, we may authorize Participating Provider cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the Covered Service. It is your responsibility to ensure that we have been contacted. If we authorize a Participating Provider cost share amount to apply to a Covered Service received from a Non-Participating Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact customer service toll free at (800) 627-8797 for Authorized Referral information or to request authorization.

ANNUAL OUT-OF-POCKET MAXIMUMS

Amounts you pay that are applied to your annual Deductible for Covered Services received from Participating Providers will also apply to the Participating Provider out-of-pocket maximum. Amounts you pay that are applied to your annual Deductible for Covered Services received from Non-Participating Providers will also apply to the Non-Participating Provider out-of-pocket maximum.

The annual out-of-pocket maximum is the amount of Copayment/Coinsurance and Deductible each Insured or family accumulates for Covered Services received in a Year.

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

- **Participating Provider Annual Out-of-Pocket Maximum**:
  - **Individual: $5,000** per Year for a single Insured enrolled in a Certificateholder only contract.
  - **Family: $10,000** per Year for a Family Contract, which is satisfied when two or more Insureds' eligible Covered Expense collectively meet this aggregate amount. Under a Family Contract, an Insured can satisfy their individual out-of-pocket maximum; however, an Insured may not contribute an amount greater than the individual annual out-of-pocket maximum toward the family out-of-pocket maximum.

Once the applicable Participating Provider out-of-pocket maximum, as stated above, has been satisfied, Anthem Blue Cross Life and Health will provide benefits at 100% of the Maximum Allowed Amount, except as specified in the "Exception" paragraph at the end of this section, for Covered Services received by the Insured from Participating Providers for the remainder of that Year.

- **Non-Participating Provider Annual Out-of-Pocket Maximum**:
  - **Individual: $9,000** per Year for a single Insured enrolled in a Certificateholder only contract.
  - **Family: $18,000** per Year for a Family Contract, which is satisfied when two or more Insureds' eligible Covered Expense collectively meet this aggregate amount. Under a Family Contract, an Insured can satisfy their individual out-of-pocket maximum; however, an Insured may not contribute an amount greater than the individual out-of-pocket maximum toward the family out-of-pocket maximum.

  Once the applicable Non-Participating Provider out-of-pocket maximum, as stated above, has been satisfied, Anthem Blue Cross Life and Health will provide benefits at 100% of the Maximum Allowed Amount, except as specified in the "Exception" paragraph at the end of this section, for Covered Services received by the Insured from Non-Participating Providers for the remainder of that Year.

Amounts you pay for Covered Services received from Non-Participating Providers will not apply toward the Participating Provider out-of-pocket maximum. In addition, amounts you pay for Covered Services received from Participating Providers will not apply toward the Non-Participating Provider out-of-maximum.

CHARGES FOR SERVICES WHICH ARE NOT COVERED OR CHARGES EXCEEDING OUR PAYMENT, SUCH AS PHYSICIAN CHARGES ABOVE THE MAXIMUM ALLOWED AMOUNT, ARE YOUR RESPONSIBILITY. THESE CHARGES ARE NOT INCLUDED IN THE TOTAL YEAR COPAYMENT/COINSURANCE CALCULATION AND MAY CAUSE YOUR PAYMENT RESPONSIBILITY TO EXCEED THE ANNUAL OUT-OF POCKET MAXIMUMS.

Exception: Copayments/Coinsurance for the following Covered Services **will not** accumulate toward satisfying the out-of-pocket maximums, and you will be required to continue to pay these amounts even after your out-of-pocket maximums have been reached. "Copayment" in this list refers to the fixed dollar amount (for example, for Infertility services, it is the $500 Copayment).

- Amounts you pay for Prescription Drugs under the Part entitled "YOUR GENERIC PRESCRIPTION DRUG BENEFITS"
- Copayment for not obtaining Preservice Review
- Acupuncture/Acupressure
- Copayment for Infertility services
- Mental or Nervous Disorders and Substance Abuse **(except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child)**

Even when the Annual Out-of-Pocket Maximums have been met, we will still apply the special limits (such as day limits or maximum payment limits) on Covered Expense for the Covered Services as described in the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

PART III HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED

Notice to Buyer: This is a limited-benefit Certificate

This Certificate is not designed to be a comprehensive medical or major medical Certificate. The benefits provided by this plan are limited, and may not cover all your medical expenses. You may have to pay substantial amounts of your own money for medical expenses, even if your illness is serious.

Amounts that do not apply toward the annual Deductibles are described in the section entitled ANNUAL DEDUCTIBLE in the Part entitled "ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNTS AND ANNUAL OUT OF POCKET MAXIMUM."

Described below are the types of services covered under this Certificate for the treatment of a covered illness, injury or condition. Before you review this list of Covered Services take a moment to review the definition of "Maximum Allowed Amount" and the items in the Part entitled ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS. Knowing the meaning of these items will greatly assist you in determining the benefits of this Certificate.

Note: Please see the "ANNUAL DEDUCTIBLES" and "ANNUAL OUT-OF-POCKET MAXIMUMS" sections in the Part entitled "ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS" for a list of Copayments that do **not** apply to the annual Deductible and/or out-of-pocket maximum.

Participating Providers: Covered Expense for Participating Providers is based on our Maximum Allowed Amount. Participating Providers have agreed **NOT** to charge you and Anthem Blue Cross Life and Health Insurance Company more than the Anthem Blue Cross Life and Health Maximum Allowed Amount. In addition, Participating Providers will file claims with us for you.

A directory of local Anthem Blue Cross Life and Health Participating Providers is available by calling our customer service department toll free at (800) 627-8797, or through our web site, **www.anthem.com**.

Non-Participating Providers: YOUR PERSONAL FINANCIAL COSTS WHEN USING NON-PARTICIPATING PROVIDERS MAY BE CONSIDERABLY HIGHER THAN WHEN YOU USE PARTICIPATING PROVIDERS. YOU WILL HAVE TO PAY ANY PART OF A PROVIDER'S BILL WHICH IS OVER WHAT WE ALLOW IN BENEFITS FOR NON-PARTICIPATING PROVIDERS.

Benefits for Covered Services received in and outside California are subject to all of the terms, conditions, limitations and exclusions of this Certificate.

See the SPECIAL CIRCUMSTANCES sections in this Part for situations that reduce your payment responsibility when utilizing a Non-Participating Provider.

Services for which Preservice Review is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following: All inpatient Hospital admissions (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admissions, Infusion Therapy per Course of Therapy (in any setting) inclusive of Specialty Drugs, and Home Health Care. You are responsible for an additional $250 Copayment per admission, treatment, or course of therapy if Preservice Review is not obtained for Non-

Participating Provider services. This Copayment does not apply toward your annual Deductible or out-of-pocket maximum and it will continue to be required even after your out-of-pocket maximum has been reached. (**Important:** Please note there are other services, not listed above, that require Preservice Review. In addition, there are other Preservice Review requirements. Please see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details.)

Note: Outpatient Hospital emergency room services are subject to an additional **$150** Copayment per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. This Copayment will not be applied toward your Deductible.

A. PARTICIPATING PROVIDER AND OUT-OF-AREA SERVICES (BLUECARD PPO PROVIDER) BENEFITS

International Plans

Benefits for Out-of-Area BlueCard PPO Provider services are provided at the same benefit level as described in the section below. Note, however, that your payment responsibility is based on the BlueCard Provider's Negotiated Price.

The following items indicate Anthem Blue Cross Life and Health payment for benefits prior to you satisfying the Annual Out-of-Pocket Maximum**:**

1. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Office Visits including related diagnostic lab and X-ray services that are not preventive care services.

   Note: All services are subject to the Deductible except Office Visits.

2. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Online Visits and Retail Health Clinic Visits.

   Note: Online Visits and Retail Health Clinic Visits are not subject to the Deductible.

3. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for covered Advanced Imaging Services. Please refer to the section in this Part entitled "Advanced Imaging Procedures" to see which procedures are covered under advanced imaging.

4. Anthem Blue Cross Life and Health payment of 100% of the Maximum Allowed Amount for Preventive Care Services. Preventive care services include Physical Exam, Well Baby, Well Child, Adult Preventive Services, women's preventive care, and related Office Visits.

   Note: Preventive care services and supplies, including Office Visits, are not subject to the annual Deductible. For more information, including certain limitations, please see the "Preventive Care" section in this Part.

5. Anthem Blue Cross Life and Health payment for Urgent Care, as follows:
   - 50% of the Maximum Allowed Amount for Urgent Care professional services, includes Office Visits.
   - 70% of the Maximum Allowed Amount for Urgent Care performed in an Urgent Care Facility.

   Note: All services are subject to the Deductible except Office Visits.

6. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount for Ambulance Services up to a maximum of $750 per trip.

7. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount up to $30 per visit for Acupuncture/Acupressure rendered by a Physician (limited to a total of 24 visits per Year for Participating and Non-Participating Providers combined.) **Note:** All supplies used in conjunction with acupuncture/acupressure treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

8. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount (limited to a maximum of thirty (30) days per Year, Participating and Non-Participating Providers combined) for Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. See DEFINITIONS for which benefits are provided for as the same as other medical conditions).

9. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount up to our medical lifetime maximum payment of $2,000 per Insured (for Participating and Non-Participating Providers combined) for Infertility Services.

   Note: Infertility services are subject to an additional $500 Copayment by the Insured.

10. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount for Skilled Nursing Facility services.

11. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount for Home Health services.

12. Anthem Blue Cross Life and Health payment of 100% of the Maximum Allowed Amount for Hospice care.

    Note: Hospice care is not subject to the annual Deductible.

13. Anthem Blue Cross Life and Health payment of 70% of the Maximum Allowed Amount incurred for all other Covered Services received from a Participating Provider.

Note: See the section entitled "Annual Out-of-Pocket Maximums" for payment of benefits after the out-of-pocket maximums have been met.

B. NON-PARTICIPATING PROVIDER AND OUT-OF-AREA BLUECARD NON-PARTICIPATING PROVIDER BENEFITS

Please see the SPECIAL CIRCUMSTANCES sections in this Part for situations that reduce your payment responsibility when utilizing a Non-Participating Provider or out-of-area BlueCard Non-Participating Provider.

The following items indicate our payment for benefits prior to you satisfying the Annual Out-of-Pocket Maximums (see the section entitled "Annual Out-of-Pocket Maximums" for payment of benefits after this limit has been met).

1. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount up to $650 per day for Hospital Inpatient services unless Special Circumstances apply.

2. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount up to $380 per admit for Hospital Outpatient services or Ambulatory Surgical Centers unless Special Circumstances apply.

3. Anthem Blue Cross Life and Health payment of 50 % of the Maximum Allowed Amount for Limited Professional Services including pre-admission testing.

4. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Office Visits including related diagnostic lab and X-ray services.

5. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Online Visits and Retail Health Clinic Visits unless Special Circumstances apply.

6. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for covered Advanced Imaging Procedures up to a maximum of $800 per procedure unless Special Circumstances apply. Please refer to the section in this Part entitled "Advanced Imaging Procedures" to see which procedures are covered under advanced imaging.

7. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Preventive Care Services. Preventive care services include Physical Exam, Well Baby, Well Child, Adult Preventive Services, women's preventive care, and related Office Visits.

   Note: Benefits are provided according to the site of service. For example, if the service is received at an outpatient Hospital facility or Ambulatory Surgical Center, benefits are covered under this section under item 2., "Hospital Outpatient or Ambulatory Surgical Centers."

8. Anthem Blue Cross Life and Health payment for Urgent Care, as follows:
   - 50% of the Maximum Allowed Amount for Urgent Care professional services, includes Office Visits unless Special Circumstances apply.
   - 50% of the Maximum Allowed Amount up to a maximum of $380 per admit for Urgent Care performed in an Urgent Care Facility unless Special Circumstances apply.

9. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Ambulance Services, up to a maximum of $750 per trip.

10. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount up to $30 per visit for Acupuncture/Acupressure rendered by a Physician (limited to a total of 24 visits per Year for Participating and Non-Participating Providers combined).

    Note: All supplies used in conjunction with acupuncture/acupressure treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

11. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount up to $175 per day, (limited to a maximum of thirty (30) days per Year Participating and Non-Participating Providers combined) for Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child. See DEFINITIONS for which benefits are provided for as the same as other medical conditions).

12. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount up to our medical lifetime maximum payment of $2,000 per Insured (for Participating and Non-Participating Providers combined) for Infertility Services.

    Note: Infertility services are subject to an additional $500 Copayment by the Insured.

13. Anthem Blue Cross Life and Health payment 50% of the Maximum Allowed Amount up to $150 per day for Skilled Nursing Facility services.

14. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount of $75 per visit for Home Health Care services.

15. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for Hospice Care unless Special Circumstances apply **OR** we will pay 50% of the Hospice rates set by Centers for Medicare and Medicaid Services (CMS – formerly HCFA) unless Special Circumstances apply.

16. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount for professional services related to Infusion Therapy up to a maximum of $50 per day for eligible professional services, and up to a combined maximum for all Infusion Therapy services (administrative, professional, and Drugs) of $500 per day.

17. Anthem Blue Cross Life and Health payment of 50% of the Maximum Allowed Amount incurred for all other Covered Services received from a Non-Participating Provider.

C. **SPECIAL CIRCUMSTANCES (In and Outside California)**

Authorized Referral Care (Out-of-Network Referrals for Non-Participating Providers)

- Anthem Blue Cross Life and Health payment is provided at 70% of the Maximum Allowed Amount for Covered Services rendered by all Non-Participating Providers (Physician, Hospital (inpatient or outpatient), Ambulatory Surgical Center) except Hospice only when the referral has been authorized by us before services are rendered.

- Anthem Blue Cross Life and Health payment is provided at 100% of the Maximum Allowed Amount for Non-Participating Hospice Providers, not subject to the annual Deductible.

D. **SPECIAL CIRCUMSTANCES (Medical Emergencies within California)**

Anthem Blue Cross Life and Health payment for Covered Services received from Non-Participating Providers will be at the Participating Provider benefit level (70% of the Maximum Allowed Amount) for Medical Emergency services as described below.

Note: Emergency room services are subject to an additional $150 Copayment by the Insured per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. The emergency room Copayment **will not** be applied toward the Insured's annual Deductible.

a. **Non-Participating Physician**

Anthem Blue Cross Life and Health payment is provided at 70% of the Maximum Allowed Amount Covered Services rendered by a Non-Participating Physician for treatment of a Medical Emergency.

b. **Non-Participating Hospital and Non-Participating Ambulatory Surgical Center**

Anthem Blue Cross Life and Health payment is provided at 70% of the Maximum Allowed Amount.

E. **SPECIAL CIRCUMSTANCES (Medical Emergencies Outside California – Out of Area Services – BlueCard Program)**

For information about the BlueCard Program please see the section "Out-of-Area Services" under the Part entitled "GENERAL PROVISIONS."

Anthem Blue Cross Life and Health payment for Covered Services received from non-participating providers will be at the BlueCard participating provider benefit level (70% of the Maximum Allowed Amount) for Medical Emergency services as described below.

1. **BlueCard non-participating Physician, non-participating Hospital, and non-participating Ambulatory Surgical Center**

Payment is provided at 70% of the Maximum Allowed Amount incurred for services rendered by a BlueCard non-participating Physician, non-participating Hospital or non-participating Ambulatory Surgical Center for treatment of a Medical Emergency.

Emergency room services are subject to an additional $150 Copayment by the Insured per visit, which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.

2. **Foreign Country Providers**

Payment is provided at 70% of the Covered Expense incurred for services rendered by a Non-Participating Physician or Non-Participating Hospital for the initial treatment of a Medical Emergency only.

Note: You are responsible at your expense for obtaining an English language translation of foreign country provider claims and any medical records that may be required.

Note: If non-Medical Emergency services are performed outside California, benefits will be paid according to the provisions in this Certificate.

F. OTHER ELIGIBLE PROVIDERS

Certain providers do not enter into Participating Provider agreements with us. Payment for the providers listed below is provided at 70% of the eligible charges.

This benefit is for the following providers:

- a blood bank,
- a respiratory therapist,
- a dentist (D.D.S.) for services related to dental injuries,
- a dispensing optician for medical services related to certain eye surgeries.

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

G. COVERED SERVICES

All Covered Services are subject to the annual Deductibles except as specifically stated in this Certificate. Amounts that do not apply toward the annual Deductibles are described in the section entitled ANNUAL DEDUCTIBLE in the Part entitled "ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS."

Inpatient Hospital (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse and Skilled Nursing Facility admissions require Preservice Review. (Important: Please note there are other services, not listed above, that require Preservice Review. In addition, there are other Preservice Review requirements. Please see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details.)

1. **HOSPITAL SERVICES** (**requires Preservice Review, except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy**)

Services are provided according to the following:

A. **Inpatient**

Covered Services

- A Hospital room with two (2) or more beds. If a private room is used, unless Medically Necessary, we will allow only up to the prevailing two-bed room rate.
- Care in special care units.
- Operating rooms, delivery rooms and special treatment rooms.
- Supplies and services such as laboratory, cardiology, pathology and radiology rendered while in the facility.
- Drugs, medicines, and oxygen given to you during your stay.
- Use of the emergency room.

Note: A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only at a CME, except for Medical Emergencies. For more information, please see the section entitled "Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery" in this Part.

Covered Dental Services

- Up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary due to an unrelated medical condition.
- Services of a Physician or dentist treating an accidental injury to your natural teeth when you receive treatment within one (1) year following the injury or within one (1) year following your Effective Date, whichever is later. Treatment excludes orthodontia and dental implants. Damage to your teeth due to chewing or biting is not an accidental injury.
- General anesthesia and associated facility charges for dental procedures in a Hospital or surgery center for enrolled Insureds if:
  a. Under seven (7) years of age; or
  b. Developmentally disabled regardless of age; or
  c. The Insured's health is compromised and general anesthesia is Medically Necessary, regardless of age.
- Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

Important: If you decide to receive dental services that are not covered under this Certificate, a Participating Provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this Certificate, please call us at the customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this Certificate.

Mental or Nervous Disorders & Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child) (Preservice Review is required for Facility Based Treatment) (See the section in this Part entitled "Pervasive Developmental Disorder or Autism" for Preservice Review requirements for those services.)

- Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse
- Day Treatment Program Center services

Note: Benefits are provided up to a maximum of thirty (30) days per Year, Participating and Non-Participating Providers combined, for Facility Based Treatment**.**

Treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child (Preservice Review is required for Facility Based Treatment.) (See the section in this Part entitled "Pervasive Developmental Disorder or Autism" for Preservice Review requirements for those services.)
Benefits for Covered Services and supplies provided for the treatment of specified Severe Mental Illness (including behavioral health treatment for Pervasive Developmental Disorder or autism) and Serious Emotional Disturbances of a Child are paid on the same basis as any other medical condition. See the Part entitled "DEFINITIONS." These services are subject to all terms, conditions, limitations, and exclusions of the Certificate.

B. **Outpatient Hospital**

Covered Services

- Emergency room use, supplies, ancillary services, Drugs and medicines as listed above.
- Care received when outpatient surgery is performed. Covered Services are operating room use, supplies, ancillary services, Drugs and medicines as listed above. These services are also payable when outpatient surgery is performed at an Ambulatory Surgical Center.
- Radiation therapy.
- Hemodialysis treatment.

Note: See the section in this Part entitled "Prescription Drugs Administered by a Medical Provider" for additional information.

Note: NO OUTPATIENT HOSPITAL BENEFITS ARE PAYABLE FOR ANY PHYSICIAN'S CHARGES EXCEPT FOR THE SERVICES OF A HOSPITAL-EMPLOYED PHYSICIAN IN CONNECTION WITH A COVERED OUTPATIENT HOSPITAL SERVICE.

Pre-Admission Testing

- Routine X-ray and laboratory examinations required in connection with a covered surgery for which a Hospital confinement is Medically Necessary. These examinations must be performed within seven (7) days prior to the Hospital confinement
- No benefits will be provided if:
  a. The X-ray and laboratory examinations are performed to establish or confirm a diagnosis, or
  b. The services are repeated when the Insured is admitted to the Hospital as an Inpatient, or
  c. An Insured cancels or postpones the admission to the Hospital.

2. **LIMITED PROFESSIONAL SERVICES AND SUPPLIES (certain services and supplies require Preservice Review)**

No benefits for professional services are provided for any care for Mental or Nervous Disorders and Substance Abuse (except for treatment of Severe Mental Illness and Serious Emotional Disturbances of a Child – see DEFINITIONS for which benefits are provided for as the same as other medical conditions), whether the care is provided for Facility Based Treatment or on an outpatient basis.

No professional benefits will be provided for any services or supplies not specifically listed here under LIMITED PROFESSIONAL SERVICES AND SUPPLIES unless otherwise stated in this Certificate, such as, but not limited to, the services of a nurse, the services of a physical or occupational therapist, Drugs, medicines, medical equipment, ambulance services, blood and blood transfusions.

- Office Visits and related services, such as X-ray and lab.
- Online visit services when available in your area. Covered Services include a medical consultation using the internet via webcam, chat or voice. Please see the Part entitled "WHAT IS NOT COVERED" for non-Covered Services.
- Services of a Retail Health Clinic.
- Drugs administered by a Physician. See the section in this Part entitled "Prescription Drugs Administered by a Medical Provider" for additional information.
- Services of a surgeon or assistant surgeon for a covered surgical procedure.
- Services of an anesthesiologist or an anesthetist for a covered surgical procedure.
- Physician visits to an Insured during a covered Hospital confinement.
- X-ray, radium and radioactive isotope therapy, whether performed on an inpatient or outpatient basis. Please refer to the section in this Part entitled "Advanced Imaging Procedures" to see which procedures are covered under advanced imaging. **Note:** Preservice Review is required for specific outpatient diagnostic radiology and certain 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 Physician, registered nurse practitioner or certified nurse midwife. This includes screening for breast, cervical, ovarian, and prostate cancer.
- Screening for blood lead levels in Children at risk for lead poisoning when the screening is ordered by your Physician.
- Mammogram examinations when ordered by your Physician, registered nurse practitioner or certified nurse midwife.
- Acupuncture/Acupressure treatment. Payment is provided up to $30 per visit for acupuncture/ acupressure rendered by a Physician (limited to a total of twenty-four (24) visits per Year for Participating and Non-Participating Providers combined). **Note:** All supplies used in conjunction with the acupuncture/acupressure treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.
- Human immunodeficiency virus (HIV) testing.
- Venereal disease tests.
- Cytology examinations
- Prenatal diagnosis of genetic disorders.
- Genetic testing and diagnostic procedures for Insureds when Medically Necessary to treat an inheritable disease.

- Diabetic daycare self-management education programs.
- Special Footwear, orthotic devices and services related to the preparation and dispensing of custom footwear that is Medically Necessary to treat an injury or illness as described under "Special Footwear" in the Part entitled "DEFINITIONS.". The coverage for Special Footwear and orthotics shall include original and replacement devices when the device is Medically Necessary and is prescribed by a Physician or is ordered by a licensed health care provider acting within the scope of his or her license.
- Prosthetic devices and services related to the preparation and dispensing of custom prosthetics. Coverage for prosthetic devices shall include original and replacement devices when the device is Medically Necessary and is prescribed by a Physician or doctor of podiatric medicine acting within the scope of his or her license. Coverage includes but is not limited to:
  - prosthetic devices to achieve symmetry after mastectomy, and
  - prosthetic devices (except electronic voice producing machines) to restore a method of speaking for the Insured after laryngectomy.

3. **AMBULANCE (requires Preservice Review in a non-Medical Emergency)**

   All ambulance services are limited to our maximum payment of $750 per trip.

   Ambulance service (base charge, mileage and non-reusable supplies) to transport you to the nearest Hospital or Skilled Nursing Facility or from a Hospital or Skilled Nursing Facility when Medically Necessary. Payment of benefits for ambulance services may be made directly to the provider of service unless proof of payment is received by us prior to the benefits being paid.

   If requested through a 911 call ambulance charges are covered if it is reasonably believed that a Medical Emergency existed, even if you were not transported to a Hospital.

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

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

4. **URGENT CARE SERVICES**

   Often an urgent rather than an emergency medical problem exists. An urgent medical problem is an unexpected illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered a Medical Emergency. Urgent medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an urgent medical problem is not life-threatening and does not require use of an emergency room at a Hospital.

   Benefits for urgent care include evaluation and treatment such as:

   - X-ray services;
   - Stabilization for simple fractures;

- Tests including, but not limited to, those for: influenza, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Simple laceration repairs; and
- Incision and drainage of an abscess.

5. **ADVANCED IMAGING PROCEDURES (requires Preservice Review)**

For more information about when X-ray services are covered, see the items entitled "Hospital" and "Limited Professional Services" in this Part. When services are received from Non-Participating Providers, Anthem Blue Cross Life and Health maximum payment limits apply.

Advanced imaging procedures include but are not limited to the following:

- Computerized Tomography (CT)
- Computerized Tomography Angiography (CTA)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology (NC)
- Positron Emission Tomography (PET)
- PET and PET/CT Fusion
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Echocardiogram

For a complete list of advanced imaging procedures or if you need more information, please call the customer service number shown on your ID card. You can also contact us on our website at **www.anthem.com**. The list of advanced imaging procedures is subject to change as medical technologies evolve.

6. **SECOND OPINIONS**

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

7. **PREVENTIVE CARE**

No Deductible, Coinsurance, or any other payment is required for preventive care services (including Office Visits) received from Participating Providers; however, preventive care services received from Non-Participating Providers are subject to the Deductible.

Preventive care services are designed to detect and prevent medical conditions in advance and help you and your family stay well. Preventive care services are developed from national guidelines recommended by such agencies as the United States Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians.

Preventive care services include but are not limited to the following: routine examinations, screenings, supplies, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. These services shall meet requirements as determined by federal and state law, including, but not limited to, the Patient Protection and Affordable Care Act (PPACA), and are to become effective in accordance with those laws. Sources for determining which services are recommended and, therefore, covered without a Coinsurance, Copayment or Deductible when received from a Participating Provider include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screenings for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   - Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Name contraceptives whether or not there is a Generic equivalent are not covered.
   - Breastfeeding support, supplies, and counseling. Breast pumps are limited to one (1) per Year.
   - Gestational diabetes screening.
   - Well-woman visits that are age and developmentally appropriate, including preconception and prenatal care.
   - Counseling for sexually transmitted infections.
   - Screening and counseling for human immunodeficiency virus (HIV).
   - Screening and counseling for interpersonal and domestic violence.

You may call customer service at (800) 627-8797 for additional information about these services, or view the federal government's web sites, at:

- http://www.healthcare.gov/center/regulations/prevention.html;
- http://www.ahrq.gov/clinic/uspstfix.htm; or
- http://www.cdc.gov/vaccines/recs/acip/.

http://www.steveshorr.com/research/PPACA/preventative_services_health_care_reform.htm

Recommended age, sex and/or frequency guidelines may apply in determining coverage. Please consult with your Physician for specific health guidelines.

Please note that the recommended frequency or nature of preventive care services may change over time due to new medical technology and developments.

Examples of preventive care Covered Services include but are not limited to the following (please note that other services may also be considered preventive):

Well Baby and Well Child Preventive Care (Insureds through age 6)

- Office Visits.
- Routine physical exams, including Physician services, medically appropriate laboratory tests, procedures and radiology services in connection with the exams.
- Screenings, including blood lead levels for children at risk for lead poisoning; vision (eye chart only) and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.

Well Child Preventive Care (Insureds ages 7 through 18)

- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the Office Visit associated with administering the injectable vaccination when ordered by your Physician.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); human papillomavirus (HPV) test for cervical cancer; and hearing screening in connection with the routine physical exam.

Adult Preventive Care

FDA-approved cancer screenings including pap examinations, breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer, prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the Office Visit related to these services.

Physical Exam (for Insureds ages 7 to adult)

- Routine physical exams
- Medically appropriate laboratory tests and procedures, and radiology procedures, in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (eye chart only), and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the Advisory Committee on Immunization Practices for Insureds age 19 and above.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

8. **PREGNANCY AND MATERNITY CARE**

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 be made only 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.

9. **INFERTILITY SERVICES**

Covered Services for Infertility are Hospital and inpatient professional charges for the following:

- Reconstructive Surgery except for sterilization reversal.
- Artificial insemination.
- In vitro fertilization.
- Gamete Intra Fallopian Transfer (GIFT).
- Zygote Intra Fallopian Transfer (ZIFT).

The above-listed services for Infertility are limited to our lifetime maximum payment of $2,000 per Insured.

Note: No benefits are available for outpatient professional services, laboratory work, or X-rays for the treatment of Infertility.

10. **INFUSION THERAPY (requires Preservice Review)**

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

Covered Services include:

- Drugs and other substances used in Infusion Therapy (please see the "Prescription Drugs Administered by a Medical Provider" section in item 11. below for additional information).
- Professional services to order, prepare, dispense, deliver, administer, train or monitor (including clinical Pharmacy support) 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.

Note: 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:

1. 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, bandages and intravenous starter kits when billed by a Non-Participating Provider. No separate benefit is provided for these services and supplies when billed by a Non-Participating Provider. When furnished by a Participating Provider, these services and supplies

are covered, but the cost is included in the charges for the Drugs and durable medical equipment used.
2. Specialty Drugs except as specifically stated below in the "Prescription Drugs Administered by a Medical Provider" paragraph.
3. Drugs and medicines not requiring a Prescription.
4. Drugs labeled "Caution, limited by federal law to Investigational use" or drugs prescribed for Experimental use, except as specifically stated under the section in this Part entitled "Cancer Clinical Trials."
5. Drugs or other substances obtained outside the United States.
6. Non-Food and Drug Administration (FDA) approved homeopathic medications or other herbal medications.
7. Charges by a Non-Participating Provider exceeding the Average Sales Price (ASP) of a Drug. The ASP includes the preparation of the finished product. The ASP is the Drug's average sales price maintained by the Centers of Medicare and Medicaid Services. The Insured will be responsible for any charges in excess of the ASP of a Drug for Non-Participating Providers.

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

11. **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER (may require Preservice Review)**

Your plan includes benefits for Prescription Drugs when they are administered to you as part of a Physician visit, Home Health Care visit, or at an outpatient facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs and blood products. This section describes your benefits when your provider orders the medication and administers it to you. Benefits are also available for Prescription Drugs that you receive under the Part entitled "YOUR GENERIC PRESCRIPTION DRUG BENEFITS."

When benefits are provided for Prescription Drugs under this section, they will not also be provided under the Part entitled "YOUR GENERIC PRESCRIPTION DRUG BENEFITS." In addition, if benefits are provided for Prescription Drugs under "YOUR GENERIC PRESCRIPTION DRUG BENEFITS," they will not also be provided under this section.

Important Requirements for Prescription Drug Coverage
Your plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Physician may be asked to provide additional information before we can determine medical necessity. We may also establish quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of the Pharmacy and Therapeutics (P&T) Process.

Preservice Review (prior authorization)
Prior authorization may be required for certain Prescription Drugs (or the quantity of a particular Drug) to ensure appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. We will contact your provider to obtain additional information required to determine whether prior authorization should be granted. We will communicate the results of the decision to both you and your provider.

If prior authorization is denied please see the Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION" for information on a grievance or dispute.

For a list of the current Drugs requiring prior authorization, please contact the telephone number on the back of your identification card. The list is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the list is not a guarantee of coverage under your plan. Your provider may check with us to verify Prescription Drug coverage, to determine whether any quantity and/or age limits apply, and to determine applicable Brand or Generic Drugs covered under the plan.

Step Therapy
Step therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. We monitor certain Prescription Drugs to control utilization and to ensure that appropriate prescribing guidelines are followed. These guidelines help you access high quality yet cost-effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the prior authorization process is applied.

Therapeutic Substitution
Therapeutic substitution is a voluntary program designed to inform you and your Physicians about possible alternatives to certain prescribed Drugs. We may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the Prescription is requested. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, call customer service at the telephone number on the back of your identification card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

12. **SKILLED NURSING FACILITY (requires Preservice Review)**

Inpatient services and supplies provided by a Skilled Nursing Facility, except private room charges over the prevailing two-bed room rate of the Skilled Nursing Facility, are limited to one hundred (100) days per Year. You must be under the active supervision of a Physician treating your illness or injury.

- A room with two (2) or more beds.
- Special treatment rooms.
- Laboratory tests.
- Physical therapy, occupational therapy, and speech therapy. Oxygen and other respiratory therapy.
- Drugs and medicines given to you during your stay.

Note: If during a stay in a Skilled Nursing Facility the Insured's care changes to Custodial Care, we will discontinue benefits as of the date the lesser level of care was required.

13. **HOME HEALTH CARE (requires Preservice Review)**

The following services of a Home Health Agency or Visiting Nurses Association are provided up to a combined maximum of one hundred (100) visits each Year for Covered Services, Participating and Non-Participating Providers combined.

A Physician must order the Home Health Care and renew the order at least once every thirty (30) days. Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.

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

1. Registered nurse or licensed vocational nurse;
2. Licensed therapist for physical, occupational, speech or respiratory therapy;
3. Medical social service worker;
4. Health aide employed by (or under arrangement with) a Home Health Agency or Visiting Nurse Association. A health aide is covered only if you are also receiving the services of a registered nurse, licensed vocational nurse, or licensed therapist employed by the same organization, and the registered nurse, licensed vocational nurse, or licensed therapist is supervising the services.
5. Private duty nurse.

We will not cover Personal Comfort Items.

All Home Health Care services and supplies related to Infusion Therapy are included in the Infusion Therapy benefit and are not covered under this Home Health Care benefit.

14. HOSPICE CARE

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

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

Hospice care is available for two 90-day periods, followed by an unlimited number of subsequent 60-day periods. Benefits will be considered only after the Insured's attending Physician and the medical director of the Hospice each certifies in writing at the beginning of each period that the Insured is terminally ill. We have the right to review any and all medical records or attending Physician's notes to verify that such certification is appropriate.

Covered Services include:

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care. An interdisciplinary team is a Hospice care team provided by the Hospice program providing care that includes the patient, the patient's family, a Physician, a registered nurse, and a social worker, and may include a volunteer and a spiritual care giver. A plan of care is a written plan that addresses the patient's needs and the needs of the family admitted to the Hospice program.
2. Short-term inpatient care arrangements.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.

4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained Hospice volunteers under the direction of a Hospice staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following your death. Bereavement services are available to surviving members of the immediate family for a period of one year after your death. Immediate family members are Spouses, Domestic Partners, children, stepchildren, parents, stepparents, siblings, stepsiblings, and legal guardians.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.
11. Medical direction, with the medical director being also responsible for meeting the general medical needs of the Insured to the extent that these needs are not met by the attending Physician.
12. Private duty nursing.

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

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

We also will make respite care available. This means short-term inpatient care provided only when necessary to relieve the family members or other persons caring for the patient. We will make respite care available only on an occasional basis and for no more than five (5) consecutive days at a time.

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

Note: Your Physician must consent to your care provided by the Hospice and must be consulted in the development of your treatment plan. The Hospice must submit a written treatment plan to us every thirty (30) days.

15. MASTECTOMY AND RELATED PROCEDURES

Benefits as described in this Certificate are payable for Hospital and inpatient professional services related to mastectomy, including the following services in connection with breast reconstruction and post-mastectomy care:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "Medically Necessary."

Benefits are paid on the same basis as any other medical condition.

16. TREATMENT FOR DIABETES

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Copayments, as any other medical condition. Benefits will be provided for Covered Expense for Diabetes Equipment, Diabetes Supplies and Diabetes Outpatient Self-Management Training Programs.

Screenings for gestational diabetes are covered under the section in this Part entitled "Preventive Care."

17. PHENYLKETONURIA (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the 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 PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU.

While formulas and special food products used in the treatment of PKU may be obtained from a Pharmacy, formulas and special food products as described in this Certificate are covered only 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 PKU, and
2. Consistent with the recommendations and best practices of qualified health professionals with expertise in the treatment and care of PKU, and
3. Used in place of normal food products, such as grocery store foods, used by the general population.

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

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

We have established a network of Hospital facilities (called Centers of Medical Excellence or CME) to provide services for specified organ transplants (heart, liver, lung, heart/lung, pancreas, kidney, simultaneous pancreas/kidney, bone marrow harvest and transplant, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) and bariatric surgical procedures.

Note: A Participating Provider in the Prudent Buyer Plan Network is not necessarily a CME facility. Information on CME facilities can be obtained by calling (800) 627-8797.

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures. **Preservice Review can be obtained by calling toll free (800) 274-7767.**

Note: Charges for bariatric procedures and related services are covered only when the bariatric procedure and related services are performed at a CME facility. Preservice Review is required.

Bariatric Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated CME that is fifty (50) miles or more from the Insured's place of residence, are covered, provided the expenses are authorized by us in advance. Insureds who reside outside California are not required to use the CME network for bariatric surgical procedures and related services. However, these Insureds are eligible for the travel expense benefit if they receive care at a bariatric CME facility that is fifty (50) miles or more from their residence. Our maximum payment will not exceed **$3,000** per surgery for the following travel expenses incurred by the Insured and/or one companion.

- Transportation for the Insured and/or one companion to and from the CME.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Meals, tobacco, alcohol and drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling customer service toll free at (800) 627-8797. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

Note: Charges for these specified transplants and related services are covered only when Medically Necessary and only when the transplant and related services are performed at a CME. Preservice Review is required.

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

- The organ or tissue recipient, and the donor is also an enrolled Insured.
- The organ or tissue donor, and the recipient is also an enrolled Insured.
- The organ or tissue recipient, and the organ or tissue donor is not an enrolled Insured. The donor is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.
- The organ or tissue donor, and the organ or tissue recipient is not an enrolled Insured. You are eligible for services as described. Benefits are reduced by any amounts paid or payable by the recipient's own coverage.
- You are an enrolled Insured who needs to store cord blood and the storage is considered Medically Necessary according to our criteria for cord blood storage at an Anthem Blue Cross Life and Health designated facility.

Organ and Tissue Transplant Donor Expense

Covered Expense for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary Covered Services only. Benefits for Covered Services incident to obtaining the transplanted organs or tissue from a living donor or human organ transplant bank will be covered except as limited by this plan. Such benefits, including complications from the donor procedure for up to six weeks from the date of procurement, are covered.

We cover cell donor search performed at a nationally accredited bone marrow/stem cell organization only for an approved bone marrow or stem cell transplant, up to a maximum **$30,000** Anthem Blue Cross Life and Health payment per transplant. Any Covered Expense incurred for these donor searches will not be applied to the Annual Out-of-Pocket Maximums.

Organ and Tissue Transplant Travel Expense

Certain **travel expenses** incurred by the Insured, up to our maximum **$10,000** payment per transplant will be covered for the recipient or donor in connection with a covered organ or tissue transplant when performed at a CME that is qualified to provide services. All travel expenses are limited to the maximum set forth in the Internal Revenue Code at the time services are rendered and must be approved by us in advance.

- Travel expenses include the following for the recipient (and one companion) or the donor:
  - Ground transportation to and from the CME facility when the CME is seventy-five (75) miles or more from the recipient's or donor's home. Air transportation by coach is available when the distance is three hundred (300) miles or more.
  - Lodging.

Note: When the recipient is under the age of eighteen (18), this benefit will apply to the recipient and two companions/caregivers.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call customer service at (800) 627-8797 for further information and/or to obtain the travel reimbursement form.

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

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 eighteen (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.

19. **PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM (requires Preservice Review)**

Benefits are provided for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this Certificate that apply to all other medical conditions, except as specifically stated in this section.

Behavioral Health Treatment
The behavioral health treatment services covered by this Certificate are those professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,

- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and

- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of applied behavioral analysis services and intensive behavioral intervention services to certain persons pursuant to which the Qualified Autism Service provider does all of the following:

    - Describes the patient's behavioral health impairments to be treated,
    - Designs an intervention plan that includes the service type, number of hours, and parental participation needed (if any) to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism, and
    - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan must not be used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and must not be used to reimburse a parent for participating in the treatment program. The treatment plan must be made available to us upon request.

Our provider network will be limited to certain Qualified Autism Service Providers who contract with Anthem Blue Cross Life and Health and who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer behavioral health treatment.

For purposes of this section, the following definitions apply:

Applied Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Pervasive Developmental Disorders means one or more of the disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, which includes Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

You must obtain Preservice Review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered. No benefits are payable for these services if Preservice Review is not obtained (see the Part entitled "UTILIZATION AND PRESERVICE REVIEW" for details).

20. CANCER CLINICAL TRIALS

Coverage is provided as described below for Insureds diagnosed with cancer and accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer if the treating Physician who is providing the health care services recommends participation in the clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Insured. The clinical trial must have 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, Deductibles, terms, conditions and limitations.

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:
    - The federal Food and Drug Administration (FDA), in the form of an Investigational new drug application,
    - One of the National Institutes of Health,
    - The United States Department of Defense, or
    - The United States Veterans Administration.

Covered Services include:

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

Covered Services do not include the following:

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

21.**TELEHEALTH**

Benefits are provided for Covered Services that are appropriately provided through Telehealth, subject to the terms and conditions of the Certificate. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the mode of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, and management of the patient's health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

PART IV WHAT IS NOT COVERED

We will not furnish benefits for:

Commercial Weight Loss Programs: Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

Dental Services: Dental treatment regardless of origin or cause, including, but not limited to:

- preventive care and fluoride treatments;
- dental implants;
- dental x-rays;
- dental supplies, appliances and all associated expenses;
- diagnosis and treatment related to teeth, jawbones or gums;
- dentures, bridges, crowns, caps, clasps, habit appliances, partials or other Dental Prostheses;
- extraction, restoration and replacement of teeth;
- services to improve dental clinical outcomes; and
- treatment for injuries that are a result of biting or chewing.

This exclusion does not apply to the following:

- services which we are required by law to cover;
- dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer; and
- services specified as covered in this Certificate.

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

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

Educational Treatment or Services that are educational, vocational, or training in nature except as specifically provided or arranged by us. This exclusion does not apply to the Medically Necessary treatment of Pervasive Developmental Disorder or autism, to the extent stated in the "Pervasive Developmental Disorder or Autism" section under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

End of Coverage: Services received after your coverage ends.

Excess Amounts: Any amounts in excess of the maximum amounts stated in the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

Expenses Before Your Coverage Begins: Services received before your Effective Date.

Experimental or Investigational: Services which are Experimental or Investigational in nature, except as specifically stated under "Cancer Clinical Trials" in the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

Food and/or Dietary Supplements: Nutritional and/or dietary supplements except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

Footwear for the treatment of weak, strained or flat feet; corns; calluses, bunions, hammertoes, fissures, plantar warts, cracks, or ingrown toenails; or conditions caused by external sources, such as ill-fitting shoes or repeated friction.

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, or by a public school system or school district, except when payment under this Certificate is expressly required by federal or state law. We 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 Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.

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

Hearing Aids. Routine Hearing Tests except where provided for under the section entitled "Preventive Care" in the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

Immunizations solely for travel outside the United States.

Infertility Services: Sterilization reversal, costs associated with the storage of sperm, eggs, embryos and ovarian tissue, and any other services for Infertility except as specifically listed in the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED." Any amount in excess of our lifetime maximum payment for Infertility services.

Mental or Nervous Disorders and Substance Abuse: Treatment of Mental or Nervous Disorders and Substance Abuse (including nicotine use) or psychological testing except as specifically stated under the benefit sections of this Certificate. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with mental or nervous conditions (for example, self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child shall be covered as any other medical condition.**

Non-Duplication of Medicare: If Medicare is an Insured's primary health plan, 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, and Medicare is your primary health plan, your Medicare coverage will not affect the services covered under the Policy, except as follows:

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

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

Non-Licensed Providers: Treatment or services provided by a non-licensed health care provider and treatment or services for which a health care provider license is not required. This includes treatment or services provided by a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by us. This exclusion does not apply to the Medically Necessary treatment of Pervasive Developmental Disorder or autism, to the extent stated in the "Pervasive Developmental Disorder or Autism" section under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

Not Medically Necessary: Any services or supplies that are not Medically Necessary as defined.

Nutritional Counseling.

Online Visits except as specifically stated under the benefit sections of this Certificate. This exclusion includes, but is not limited to, communications used for: reporting normal lab or other test results; office appointment requests; billing, insurance coverage or payment questions; requests for referrals to doctors outside the online care panel; obtaining Preservice Review; and Physician-to-Physician consultations.

Orthodontic Services: Braces, other orthodontic appliances and orthodontic services, except for orthodontic services related to Reconstructive Surgery for cleft palate as specifically stated for dental-related benefits under the benefit sections of this Certificate.

Outdoor Treatment Programs.

Outpatient Speech Therapy: Outpatient speech therapy.

Personal Comfort Items: Items which are furnished primarily for your comfort or convenience, including, but not limited to air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, shoes, elevators, hairpieces, diapers and supplies for comfort, hygiene or beautification.

Physical and/or Occupational Therapy/Medicine or chiropractic services, except when provided during an inpatient Hospital confinement.

Preexisting Conditions: No payment will be made for services or supplies for the treatment of a Preexisting Condition during a period of six (6) months following the date the Insured's coverage under this Certificate is effective. However, this limitation does not apply to:

- an Insured under age nineteen (19),
- a Child acquired through legal guardianship if the Child is added within thirty-one (31) days of final court decree or order,
- a Child born to or newly adopted by an enrolled Certificateholder or Spouse, or
- conditions of pregnancy.

There is no Preexisting Condition waiting period, limitation or exclusion for any Insured under the age of nineteen (19).

Preexisting Condition means an illness, injury, disease or physical condition for which medical advice, diagnosis, care or treatment, including the use of Prescription Drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the earlier of: the first day of the waiting period (applicable to newly hired employees) or the date the Insured's coverage under this Certificate is effective. **Creditable Coverage** is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, or coverage under a publicly sponsored program such as CHAMPUS, Indian Health Service or tribal organization medical coverage, Peace Corps medical coverage, a state health benefits risk pool, Medicare or Medicaid. Creditable Coverage does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans.

1. We will reduce this six (6) month period if you were covered under Creditable Coverage and, within not more than sixty-two (62) days of termination of that coverage, you became eligible and applied for coverage under the Policy, the time spent under the Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

2. We will also reduce this six (6) month period if an Insured's employment has ended, the availability of health coverage offered through employment or sponsored by an Employer has terminated, or an Employer's contribution toward health coverage has terminated, provided the Certificateholder becomes eligible for health coverage offered through employment or sponsored by an Employer within 180 days of termination of the Creditable Coverage and applies for coverage within thirty (30) days of becoming eligible for coverage under the Policy.

Note: You have the right to obtain proof of Creditable Coverage from your prior plan. Please contact customer service at (800) 627-8797 if you have any questions regarding preexisting conditions.

Private Duty Nursing except as expressly provided under the sections entitled "Home Health Care" and "Hospice Care."

Replacement of prosthetics and durable medical equipment when lost, or stolen.

Routine Physical Exams except as specifically stated under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."

Services from Relatives: Professional and other Covered Services provided in the home by a person who lives in the Insured's home or who is related to the Insured by blood, marriage or adoption.

Services You Receive for Which You Have No Legal Obligation to Pay: Services you actually receive for which you have no legal obligation to pay or for which no charge would be made if you did not have a health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: (a) it must be internationally known as being devoted mainly to medical research, and (b) at least ten percent of its yearly budget must be spent on research not directly related to patient care, and (c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and (d) it must accept patients who are unable to pay, and (e) 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. This includes any medical, surgical or psychiatric treatment or study related to sex changes.

Surrogate Mother Services: Any services or supplies provided to any person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Telephone, E-Mail and Facsimile Machine Consultations: Consultations provided by telephone, electronic mail or facsimile machines.

Unlisted Services: Services not specifically listed in this Certificate as Covered Services.

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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

Weight Reduction: Services primarily for weight reduction or treatment of obesity, or any care which involves weight reduction as the main method of treatment, except Medically Necessary treatment of morbid obesity (which requires Preservice Review), including bariatric surgery as stated under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED," in the "Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery" section.

Workers' Compensation: Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under 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 any workers' compensation law or similar law, we will provide the benefits of this plan for such conditions, subject to our right to a lien or other recovery under section 4903 of the California Labor Code, or other applicable law.

PART V UTILIZATION AND PRESERVICE REVIEW

This plan includes the processes of Preservice, Admission, Continued Stay and Retrospective Reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This plan requires that Covered Services be Medically Necessary for benefits to be provided.

Certain services require Preservice Review of benefits in order for benefits to be provided. Participating Providers will initiate the review on your behalf. A Non-Participating Provider may or may not initiate the review for you. In both cases, it is your responsibility to initiate the process and ask your Physician to request Preservice Review. You may also call us directly. Preservice Review criteria are based on multiple sources including medical policy, clinical guidelines, and Pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments that are more cost-effective.

It is your responsibility to determine whether a particular service requires Preservice Review. Please read the information that follows to assist you in this determination and please feel free to visit www.anthem.com or call the toll-free number for Preservice Review printed on your identification card if you have any questions about making this determination.

IMPORTANT: Utilization 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 the Policy.

A. **Preservice Review**: We will determine **in advance** whether certain procedures and admissions are Medically Necessary and are the appropriate length of stay, if applicable. Services for which Preservice Review is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

1. All inpatient Hospital admissions (except inpatient Hospital stays for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy);
2. Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse (see the Part entitled DEFINITIONS);
3. Skilled Nursing Facility admissions;
4. Center of Medical Excellence (CME) procedures, including Organ and Tissue Transplants, Coronary Artery Bypass Surgeries, peripheral stem cell replacement and similar procedures;
5. Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services for each course of treatment in any setting, including but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting;
6. Home Health Care;
7. Specific outpatient services, including diagnostic treatment and other services;
8. Specific surgical procedures, wherever performed, as specified by us;
9. Specific diagnostic procedures, including advanced imaging procedures, wherever performed, such as:
   a) Computerized Tomography (CT)
   b) Computerized Tomography Angiography (CTA)
   c) Magnetic Resonance Imaging (MRI)

d) Magnetic Resonance Angiography (MRA)
e) Magnetic Resonance Spectroscopy (MRS)
f) Nuclear Cardiology (NC)
g) Positron Emission Tomography (PET)
h) PET and PET/CT Fusion
i) QTC Bone Densitometry
j) Diagnostic CT Colonography
k) Echocardiogram

10. Air ambulance in a non-Medical Emergency;
11. Behavioral health treatment for Pervasive Developmental Disorder or autism, as specified in the section entitled "Pervasive Developmental Disorder or Autism" under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED."
12. Other services wherever they are rendered.

For a list of current procedures, requiring Preservice Review, please call the toll-free number for customer service printed on your identification card.

To initiate Preservice Review, instruct your Physician to request Preservice Review at least five (5) working days before any non-urgent scheduled Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admission, outpatient surgery, Infusion Therapy (in any setting) inclusive of Specialty Drugs, Home Health Care or treatment, therapy, service and supply that requires Preservice Review by calling us toll free at (800) 274-7767. But remember, you are responsible to see that it is done.

The review processes which may be undertaken are listed in paragraphs B. through F. that follow.

B. The Anthem Blue Cross Life and Health Utilization Review Program evaluates only the medical need for Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility admissions, outpatient surgeries or other services received. This process determines whether the Hospital admission or outpatient surgery performed at a Hospital or Ambulatory Surgical Center is Medically Necessary.

C. **When Preservice Review is required, you will be responsible for initiating Preservice Review.** Remember, it is your responsibility to call the toll-free number printed on your identification card or visit **www.anthem.com** to determine whether a particular service requires Preservice Review.

Whenever Preservice Review has not been performed for the following services received from a Non-Participating Provider, you will be required to pay an additional $250 Copayment for the admission, treatment, or therapy: an admission to a Hospital (except for the delivery of a Child or mastectomy surgery, including the length of Hospital stays associated with mastectomy), Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility, Infusion Therapy (in any setting) and Home Health Care. **This Copayment is in addition to any other Copayment required by this Certificate. It will NOT apply toward satisfying your annual Deductibles or Annual Out-of-Pocket Maximums and it will continue to be required even after your Annual Out-of-Pocket Maximums have been reached.**

D. **Admission Review.** We will determine at the time of admission if the Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, Skilled Nursing Facility stay or surgery is Medically Necessary in the event Preservice Review is not conducted except for inpatient Hospital stays related to the delivery of a Child or mastectomy surgery.

E. **Continued Stay Review.** We will also determine if a continued Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, or Skilled Nursing Facility stay is Medically Necessary. The length of Hospital stays related to mastectomy will be determined by the treating Physician in consultation with the patient.

F. **Retrospective Review.** We will determine if a scheduled or Medical Emergency admission to a Hospital, Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse, or any surgery at a Hospital or an Ambulatory Surgical Center was Medically Necessary in the event that Preservice Review, Admission Review or Continued Stay Review was not performed.

G. **Revoking or modifying a Preservice Review decision.** Anthem Blue Cross Life and Health will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

- Your coverage under this Certificate ends;
- The Policy with the Group terminates;
- You reach a benefit maximum that applies to the service in question;
- Your benefits under this Certificate change so that the service is no longer covered or is covered in a different way.

For a copy of the Medical Necessity Review Process, please contact our customer service department toll free at (800) 627-8797.

Anthem Blue Cross Life and Health may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) if such change is in furtherance of the provision of cost-effective, value based and/or quality services.

In addition, we may select certain qualifying providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem Blue Cross Life and Health exempts a process, provider or claim from the standards which otherwise would apply, it does not mean that Anthem Blue Cross Life and Health will do so in the future, or will do so in the future for any other provider, claim or Insured. Anthem Blue Cross Life and Health may stop or modify any such exemption with or without advance notice.

You may determine whether a provider is participating in certain programs by checking your on-line Provider Directory, accessing our web site at **www.anthem.com** or calling the toll-free number for customer service printed on the back of your ID card.

PART VI ALTERNATIVE BENEFITS

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

Anthem Blue Cross Life and Health makes treatment suggestions only; any decision regarding treatment belongs to the Insured and the Insured's Physician. When alternative treatments are to be provided, both the Insured (or Insured's guardian) and the Insured's Physician must agree, in writing, with the terms and conditions of our recommended substitution of benefits. Alternative benefits paid are accumulated toward any lifetime maximums under this Certificate.

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

PART VII YOUR GENERIC PRESCRIPTION DRUG BENEFITS

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

When benefits are provided for Prescription Drugs under this Part, they will not also be provided under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED." In addition, if benefits are provided for Prescription Drugs under "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED," they will not also be provided under this Part.

We use a Generic Prescription Drug Formulary to help your doctor make prescribing decisions. The presence of a Drug on the plan's Formulary does not guarantee that it will be prescribed by your Physician. Your Prescription Drug benefits cover only Generic Prescription Drugs listed in the Small Group GenRx Formulary. Formulary Drugs may change from time to time. If you have a question regarding whether a Generic Drug is listed on the Small Group GenRx Formulary, please call the customer service number listed on your ID card. For your convenience, the Small Group GenRx Formulary can be accessed online at **www.anthem.com** or, if you would like a copy of the formulary, please contact us.

The Pharmacy and Therapeutics (P&T) Process determines which outpatient Generic Prescription Drugs are to be included on the list of Formulary Drugs covered by the plan. The P&T Process is a process in which independent doctors and pharmacists meet quarterly and decide on changes to make on the Formulary based on our recommendations and a review of relevant information, including current medical literature.

Some medications may require prior authorization from us. Please call the customer service number listed on your ID card for a list of these Drugs or you may review the Prior Authorization Guidelines online at **www.anthem.com**. You may also wish to refer to the "Prior Authorization" section in this Part for more information.

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

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

For an explanation of your Prescription Drug coverage when you are enrolled in Medicare Part D, see the Part entitled, "BENEFITS FOR MEDICARE ELIGIBLE INSUREDS."

DEFINITIONS

- **Brand Name Prescription Drug (Brand Name)** is a Prescription Drug that has been patented.
- **Drugs (Prescription Drugs)** mean medications approved by the state of California Department of Health or the Food and Drug Administration (FDA) for general use by the public which requires a Prescription before the medication can be obtained. For purposes of this benefit, Insulin will be deemed a Prescription Drug.

- **Formulary (Small Group GenRx Formulary)** is a list of Generic Drugs covered under this Part which we have 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 FDA 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.
- **Non-Participating Pharmacy** is a Pharmacy which does not have a contract in effect with the Pharmacy Benefits Manager 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 contract in effect with the Pharmacy Benefits Manager at the time services are rendered. To identify a Participating Pharmacy, call your local Pharmacy directly or call us toll free at the customer service number listed on your ID card.
- **Pharmacy** means a licensed retail Pharmacy.
- **Pharmacy and Therapeutics (P&T) Process** is a process in which health care professionals including nurses, pharmacists, and Physicians determine the clinical appropriateness of Drugs and promote access to quality medications. The process also reviews Drugs to determine the most cost-effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.
- **Pharmacy Benefits Manager (PBM)** is the entity which administers Anthem Blue Cross Life and Health Insurance Company's Prescription Drug benefits. The PBM is an independent contractor and not affiliated with Anthem Blue Cross Life and Health.
- **Prescription** means a written order issued by a Physician.
- **Prescription Drug Maximum Allowed Amount** is the maximum amount allowed for Prescription Drugs. The amount is determined by us using Prescription Drug cost information provided to us by the PBM. The Prescription Drug Maximum Allowed Amount is subject to change. You may determine the Prescription Drug Maximum Allowed Amount of a particular Prescription Drug by calling the customer service number listed on your ID card.
- **Self-Administered Injectable Drugs** are injectable Generic Drugs which are self-administered by the patient (or family member), including Drugs with FDA labeling for self-administration.

DRUG UTILIZATION REVIEW

Your Prescription Drug benefits include Utilization Review of Generic Prescription Drug usage for your health and safety. Certain Generic Drugs may require prior authorization. Also, a participating pharmacist can help arrange prior authorization or dispense an emergency amount of a covered Generic Drug. If there are patterns of over utilization or misuse of Drugs, we will notify your personal Physician and your pharmacist.

PRIOR AUTHORIZATION

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

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

In order for you to obtain a Drug that requires prior authorization, your Physician must make a written request to us using a Drug Prior Authorization form. The form can be faxed or mailed to us. If your Physician needs a copy of the form, he or she may call us at (800) 627-8797 to request one. The form is also available online at **www.anthem.com**.

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

- We will review it and decide if we will approve benefits within 72 hours or if shorter, the time required by state or federal law. (As soon as we can, based on your medical condition, as Medically Necessary, we may take less than 72 hours to decide if we will approve benefits.) We will tell you and your Physician what we have decided in writing – by fax to your Physician and by mail to you.

- If more information is needed to make a decision, or we cannot make a decision for any reason, we will tell your Physician, within 24 hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell your Physician what information is missing within 24 hours, we will tell your Physician that there is a problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell you and your Physician that there is a problem in writing by fax, and, when appropriate, by telephone to your Physician, and in writing by mail to you.

- As soon as we can, based on your medical condition, as Medically Necessary, but not more than 48 hours after we have all the information we need to decide if we will approve benefits, we will tell you and your Physician what we have decided in writing – by fax to the Physician and by mail to you.

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

- Based on your medical condition, as Medically Necessary, we will review it and decide if we will approve benefits within five (5)-business days or if shorter, the time required by state or federal law. We will tell you and your Physician what we have decided in writing – by fax to your doctor and by mail to you.

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

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

If you have any questions whether a Drug is on our Small Group GenRx Formulary or requires prior authorization, please call the customer service number listed on your ID card.

If prior authorization of a Drug is not approved, you or your prescribing Physician may appeal our decision by calling us at (800) 627-8797. If you are not satisfied with the resolution based on your inquiry, please see the Parts entitled “INDEPENDENT MEDICAL REVIEW OF GRIEVANCES” and “BINDING ARBITRATION” for any grievance or dispute.

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 Certificate ends;
- The Policy with the Group terminates;
- You reach a benefit maximum that applies to Prescription Drugs, if this Certificate includes such a maximum;
- Your Prescription Drug benefits under this Certificate 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 the unfilled portions or remaining refills of the Prescription, if any, and not to Drugs you have already received.

WHAT IS COVERED

If listed on the Small Group GenRx Formulary, the following Generic Prescription Drugs are covered under this Part:

- Outpatient Generic Drugs and medications which federal and/or state of California law restrict to sale by Prescription only.
- Insulin. Diabetic supplies such as syringes prescribed and dispensed for use with Insulin, and lancets and test strips for use in monitoring diabetes.
- Oral contraceptive Generic Drugs prescribed for birth control. If your Physician determines that oral contraceptive Drugs are not medically appropriate, coverage for another FDA approved Prescription contraceptive method will be provided. Certain contraceptive Drugs are covered as preventive care. Please see the "Preventive Care" section under the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED" for further details.
- Generic Drugs and medications prescribed for the treatment of impotence and/or sexual dysfunction must be authorized in advance by us and are limited to eight (8) tablets/units per 30-day period. **(Not covered under the home delivery program.)**
- Generic Drugs and medications prescribed for the treatment of Infertility are limited to our lifetime maximum payment of $1,500 per Insured.
- Influenza immunization (flu vaccine), including administration by injection or inhalation and the pneumonia vaccine.

CONDITIONS OF SERVICE

We only pay benefits for Drugs or medicines that:

- Are a Generic form of the Prescription and listed on the Small Group GenRx Formulary.
- Are prescribed in writing by a Physician and dispensed by a licensed retail pharmacist or by mail through the home delivery program within one year of being prescribed, subject to federal or state laws. This requirement will not apply to seasonal flu and pneumonia vaccinations provided at a Participating Pharmacy.
- Are approved for use by the Food and Drug Administration (FDA).
- Are for the direct care and treatment of the Insured's illness, injury or condition; however, seasonal flu and pneumonia vaccinations provided at a Participating Pharmacy are covered. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not covered.
- Are purchased from a licensed retail Pharmacy, or ordered by mail through the home delivery program.
- Are not used while the Insured is an inpatient in any facility.

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

BENEFIT PAYMENTS WHEN YOU GO TO A PARTICIPATING PHARMACY

When you present your identification card at a Participating Pharmacy, you will have to pay the applicable amount listed below for each covered Prescription and/or refill up to a 30-day supply for Drugs on the Small Group GenRx Formulary. If the retail price for a covered Generic Prescription and/or refill is less than the applicable amount listed below, you will not be required to pay more than the retail price.

Generic Drugs:

- $15

Self-Administered Injectable Drugs:

- 30% of the Prescription Drug Maximum Allowed Amount up to a maximum $150 Insured payment for Self-Administered Injectable Drugs as listed on the Small Group GenRx Formulary, except for Insulin.

Flu and Pneumonia Vaccines:

- No Copayment

Prescription oral contraceptives (Generic contraceptives only):

- No Copayment

LIMITED BENEFITS WHEN YOU GO TO A NON-PARTICIPATING PHARMACY

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

Pharmacy Benefits Manager
Prescription Drug Program
Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Claim forms and customer service are available by calling the customer service number listed on your ID card. Mail the claim form with the appropriate portion completed and signed by the pharmacist to the PBM no later than fifteen (15) months after the date of dispensing.

The Rate of Reimbursement is as Follows:

- **When your covered Generic Prescription is filled at a Non-Participating Pharmacy <u>within</u> the state of California:** The reimbursement will be 50% of the Prescription Drug Maximum Allowed Amount.

- **When your covered Generic Prescription is filled at a Non-Participating Pharmacy <u>outside</u> the state of California:** The reimbursement will be the Prescription Drug Maximum Allowed Amount, less the amounts as stated for Participating Pharmacies.

WHEN YOU ORDER BY MAIL THROUGH THE HOME DELIVERY PROGRAM

Your home delivery program is administered by the PBM. Your home delivery Prescription is filled by an independent, licensed Pharmacy. We do not dispense Drugs or fill Prescriptions.

Maintenance Drugs (an ongoing Prescription) listed on the Small Group GenRx Formulary can be purchased by mail, requiring the following amount to be submitted for each covered Prescription and/or refill up to a 90-day supply:

Generic Drugs:

- $15

Self-Administered Injectable Drugs:

- 30% of the Prescription Drug Maximum Allowed Amount up to a maximum of $300 Insured payment for Self-Administered Injectable Drugs as listed on the Small Group GenRx Formulary, except for Insulin.

Prescription oral contraceptives (Generic contraceptives only):

- No Copayment

Note: Some Prescription Drugs and/or medicines may not be available or are not covered for purchase through the home delivery program (including, but not limited to, antibiotics, Drugs not on the Small Group GenRx Formulary, Drugs and medications for the treatment of Infertility, and injectables, including Self-Administered Injectables except Insulin). Please call customer service toll free at (866) 297-1013 to check availability of the Drug or medicine.

SPECIAL PROGRAMS

Special Programs

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

Half-Tablet Program

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

WHAT IS NOT COVERED

IN ADDITION TO ANY LIFETIME MAXIMUMS FOR SPECIFIED SERVICES, LIMITATIONS ON PREEXISTING CONDITIONS OR ANY OTHER EXCLUSIONS OR LIMITATIONS CONTAINED IN THIS ENTIRE CERTIFICATE, PRESCRIPTION DRUGS AND REIMBURSEMENT WILL NOT BE FURNISHED FOR:

- Prescription Drugs that are not listed on the Small Group GenRx Formulary.
- Brand Name Drugs, except as listed on the Small Group GenRx Formulary.
- Compound medications
- Drugs or medications which may be obtained without a Physician's Prescription, except Insulin and Niacin for cholesterol lowering.
- All Prescription and non-Prescription herbs, botanicals, and nutritional supplements which have not been approved by the FDA to diagnose, treat, cure or prevent a disease.
- Non-medicinal substances or items.
- Over-the-counter smoking cessation drugs. This does not apply to Medically Necessary Drugs that you can only get with a Prescription under state and federal law.
- Drugs and medications used to induce non-spontaneous abortions.
- Dietary supplements, vitamins, cosmetics, health or beauty aids, or similar products which have not been approved by the FDA to diagnose, treat, cure or prevent a medical condition.
- Drugs taken while you are in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent Hospital or similar facility.
- Any expense incurred in excess of the Prescription Drug Maximum Allowed Amount.
- Any drug labeled "Caution, limited by federal law to Investigational use" or non-FDA approved Investigational drugs. Any drug or medication prescribed for Experimental indications (e.g., progesterone suppositories).
- Syringes and/or needles, except those dispensed for use with Insulin.
- Durable medical equipment, devices, appliances, and supplies, except lancets and test strips for use in the monitoring of diabetes.
- Immunizing agents, except as specifically stated as covered in this Part, biological sera, blood, blood products or blood plasma.
- Oxygen.
- Professional charges in connection with administering, injecting or dispensing Drugs.
- All Infusion Therapy and medications except Self-Administered Injectables and aerosols.
- Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities, doctors' offices and home IV therapy.
- Drugs when used for cosmetic purposes.
- Drugs when used for the primary purpose of treating Infertility in excess of our lifetime maximum payment of $1,500 per Insured.
- Drugs used for weight loss, except when Medically Necessary.
- Drugs obtained outside the United States.
- Allergy desensitization products, allergy serum.
- A Prescription dispensed in excess of a 30-day supply (unless ordered by mail through the home delivery program, in which case the limit is a 90-day supply).
- Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent.
- Replacement of Drugs and medications when lost, stolen or damaged.

CLAIMS AND CUSTOMER SERVICE

For retail Pharmacy information, please write to:

Pharmacy Benefits Manager
Prescription Drug Program
Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

or call toll free: (800) 627-8797

For home delivery program information, please write to:

Pharmacy Benefits Manager
Standard Accounts
Home Delivery Program
P.O. Box 66558
St. Louis, MO 63166-6558

or call toll free: (866) 297-1013

You may also access our web site at **www.anthem.com** for information about retail or home delivery programs.

PART VIII BENEFITS FOR MEDICARE ELIGIBLE INSUREDS

The Policy is **not** a supplement to Medicare. The Policy provides benefits according to a **Non-Duplication of Medicare clause**. When an Insured becomes eligible for Medicare benefits, Anthem Blue Cross Life and Health automatically becomes the secondary health plan for Insureds meeting any of the following criteria:

A. Insureds who are age sixty-five (65) or older and insured under the Policy through an Employer Group of less than twenty (20) employees.
B. Insureds who are eligible for Medicare due to a disability and are under age sixty-five (65).
C. Insureds any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant, sometimes called ESRD) following a thirty (30) month coordination period with Medicare. The coordination period begins when the following occurs:
   - Three (3) months of kidney dialysis treatments for end-stage renal disease have ended or
   - Insureds have received a kidney transplant within the first three (3) months after starting a course of kidney dialysis treatments for end-stage renal disease, or
   - Insureds have enrolled in a self-dialysis training program, and received training for home dialysis for treatment of end-stage renal disease.

Note: Anthem Blue Cross Life and Health remains the primary health plan for Medicare beneficiaries not meeting any of the above-listed criteria.

NON-DUPLICATION OF MEDICARE BENEFITS

Medicare Part A provides benefits for Hospital services while Medicare Part B provides benefits for professional services including doctor's office, laboratory and other outpatient services. **If Medicare is an Insured's primary health coverage, it is important that the Insured enroll in both Parts A and B of Medicare**.

If Medicare is an Insured's primary health plan, 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, and Medicare is your primary health plan, your Medicare coverage will not affect the services covered under the Policy, except as follows:

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

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

PART IX GENERAL PROVISIONS

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

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

Relationship of Parties: We are not responsible for any claim for damages or injuries suffered by the Insured while receiving care in any Hospital, Skilled Nursing Facility, Physician's office or Home Health Care Agency. Such facilities act as independent contractors.

Workers' Compensation Insurance: The Policy and this Certificate do not take the place of or affect any requirement for, or coverage by, workers' compensation insurance.

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

Submission of Claims: Either the Certificateholder or provider of service must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by us within fifteen (15) months from the date the services or supplies are received. We will not be liable for benefits if we do not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available by accessing our web site at **www.anthem.com**, by calling toll free (800) 627-8797, or by writing to us at the address in the next sentence. Claims should be submitted to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 60007, Los Angeles, CA 90060-0007.

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 Life and Health Insurance Company at the address indicated on your identification card.

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

Right of Recovery: Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover from the provider a payment made in error, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if Anthem Blue Cross Life and Health pays to the healthcare provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, Anthem Blue Cross Life and Health may collect such amounts directly from you. You agree that Anthem Blue Cross Life and Health has the right to collect such amounts from you.

We have oversight responsibility for compliance with provider, vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

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. This right is subject to all applicable confidentiality requirements. By submitting an application for coverage, you have authorized every provider furnishing care to disclose all facts 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 REGARDING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. PLEASE CONTACT OUR CUSTOMER SERVICE DEPARTMENT AT (800) 627-8797 TO OBTAIN A COPY.

Terms of Coverage:

- In order for you to be entitled to benefits under the Policy, both the Policy (Group) and your coverage under the Policy must be in effect on the date the expense giving rise to a claim for benefits is incurred.

- The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which a charge is made.

- The Policy and this Certificate are subject to amendment, modification or termination according to the provisions of the Policy without your consent or concurrence. Your entitlement to any increase in benefits as a result of any amendment or modification of the Policy or this Certificate is subject to the provisions found under the Part entitled “WHO IS COVERED AND WHEN.”

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

Payment to Providers and Provider Reimbursement: Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals or other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis. We pay the benefits of this Certificate directly to Participating Providers (e.g., Hospitals, Physicians, medical transportation providers, certified nurse midwives and registered nurse practitioners), whether or not you have authorized assignment of benefits. We may pay directly Hospitals, Physicians and other providers of service, or the person or persons having paid for your Hospital or medical services, when you assign benefits in writing no later than the time of filing proof of loss (claim). These payments fulfill our obligation to you for those services. If you receive Covered Services from a Non-Participating Provider payment may be made directly to the Certificateholder, and, in that situation, you will be responsible for payment to that provider. An assignment of benefits, even if assignment includes the provider's right to receive payment, may be void unless an Authorized Referral has been approved by us. We will pay Non-Participating Providers and other providers of service directly when Medical Emergency services and care are provided to you. We will continue such direct payment until the emergency care results in stabilization.

Termination of Providers: We will provide you with a notice of termination of a general acute Hospital from which you are receiving a course of treatment at least sixty (60) days in advance of the effective date of termination. To locate another Hospital in your area, call our customer service department at (800) 627-8797.

Transition Assistance for New Insureds: Transition Assistance is a process that allows for continuity of care for new Insureds receiving services from a Non-Participating Provider. If you are a new Insured, you may request Transition Assistance if any one of the following conditions applies:

1. 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.
2. 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 us in consultation with the Insured and the Non-Participating Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Insured enrolls with us.
3. 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.
4. 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.
5. 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 time the Insured enrolls with us.
6. 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 time the Insured enrolls with us.

Please contact customer service toll free at (800) 627-8797 to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the Policy.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, the Insured will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this plan. Financial arrangements with Non-Participating Providers are negotiated on a case-by-case basis. We will request that the Non-Participating Provider agree to negotiate reimbursement and/or contractual requirements that apply to Participating Providers, including payment terms. If the Non-Participating Provider does not agree to negotiate said reimbursement and/or contractual requirements, we are not required to continue that provider's services. If the Insured does not meet the criteria for Transition Assistance, the Insured is afforded due process including having a Physician review the request.

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

1. The Insured must be under the care of the Participating Provider at the time of our termination of the provider's participation. The terminated provider must agree in writing to provide services to the Insured in accordance with the terms and conditions of his/her agreement with Anthem Blue Cross Life and Health Insurance Company prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem Blue Cross Life and Health Insurance Company prior to the 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. We 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 Blue Cross Life and Health in consultation with the Insured and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
    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 voluntarily leave their provider group network, providers who choose not to renew their agreement, or providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

4. Please contact customer service toll free at (800) 627-8797 to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Policy.

We will notify you by telephone, and the provider by telephone and fax, as to whether or not your request for continuation of care is approved. If approved, the Insured will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this 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 negotiate said 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 Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION."

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

Responsibility to Pay Providers: In accordance with Anthem Blue Cross Life and Health Insurance Company's Participating Provider agreements, Insureds will not be required to pay any Participating Provider for amounts owed to that provider by us (not including Coinsurance, Copayments, Deductibles and services or supplies that are not a benefit of the Policy), even in the unlikely event that we fail to pay the provider. Insureds are liable, however, to pay Non-Participating Providers for any amounts not paid to them by us.

Expense in Excess of Benefits: We are not liable for any expense you incur in excess of the benefits of this Certificate.

Providing of Care: We are not responsible for providing any type of Hospital, medical or similar care.

Non-Regulation of Providers: Benefits provided under this Certificate do not regulate the amounts charged by providers of medical care.

Plan Administrator – COBRA and ERISA: In no event will we be plan administrator for the purpose of compliance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Employee Retirement Income Security Act (ERISA). The term "plan administrator" refers either to the Group or to the person or entity other than us engaged by the Group to perform or assist in performing administrative tasks in connection with the Group's health plan. The Group is responsible for satisfaction of notice, disclosure and other obligations of administrators under ERISA. In providing notices and otherwise performing according to the provisions stated under the Part entitled "CONTINUATION OF COVERAGE COBRA," the Group is fulfilling statutory obligations imposed on it by federal law and, where applicable, acting as your agents.

OUT-OF-AREA SERVICES

Anthem Blue Cross Life and Health has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem Blue Cross Life and Health's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem Blue Cross Life and Health and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem Blue Cross Life and Health's service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating providers. Anthem Blue Cross Life and Health's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, Anthem Blue Cross Life and Health will remain responsible for fulfilling Anthem Blue Cross Life and Health's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

Whenever you access Covered Services outside Anthem Blue Cross Life and Health's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The Negotiated Price that the Host Blue makes available to Anthem Blue Cross Life and Health.

Often, this "Negotiated Price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem Blue Cross Life and Health uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

CARE OUTSIDE THE UNITED STATES—BLUECARD WORLDWIDE

Prior to travel outside the United States, check with your Employer/Group or call the customer service number on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the customer service number on your ID card for coverage details. **You have coverage only for Medical Emergency services when traveling outside the United States.**
- Always carry your current Anthem Blue Cross Life and Health ID card.
- In an emergency, go directly to the nearest hospital.
- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll free at (800) 810-BLUE (2583) or by calling collect (804) 673-1177**. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- **You need to find a doctor or hospital or need medical assistance services**. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.
- **You need to be hospitalized or need inpatient care**. After calling the Service Center, you must also call Anthem Blue Cross Life and Health for Preservice Review, at the phone number on your ID card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- Participating BlueCard Worldwide hospitals. In most cases, when you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay up front for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The hospital should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will need to pay up front for outpatient services, care received from a doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- **The hospital will file your claim** if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem Blue Cross Life and Health.

Claim Forms – International claim forms are available from Anthem Blue Cross Life and Health, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

PART X EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

The federal Employee Retirement Income Security Act of 1974 (ERISA) contains certain claim procedure rules. These rules, detailed in this Part, govern any claim or request for benefits, including Preservice Review for medical services. Preservice Review, when required by the plan, is considered to be part of a claim and is subject to ERISA procedure rules.

Under ERISA, any dispute regarding an adverse benefit decision may be submitted to voluntary binding arbitration only after the Insured has followed the ERISA appeal procedures. For an Insured enrolled in a plan subject to ERISA, any dispute which does not involve an adverse benefit decision is subject to binding arbitration (please see the Part entitled "BINDING ARBITRATION").

This Certificate contains information on reporting claims, including the time limitations for submitting a claim. Claim forms may be obtained from the plan administrator or from Anthem Blue Cross Life and Health. If your Employer provides any plan that is subject to ERISA, ERISA applies some additional claim procedure rules, which are set forth throughout this Part. To the extent that ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Certificate.

A Participating Pharmacy's failure to fill a Prescription for you is not considered a claim under your plan. However, in the event that a Participating Pharmacy fails to fill a Prescription for you, or if you request a Prescription from a Non-Participating Pharmacy, you may submit a claim for the Prescription to us. For information on submitting a Pharmacy claim, please refer to the Part entitled "YOUR GENERIC PRESCRIPTION DRUG BENEFITS."

Note: To determine if your plan is subject to ERISA, check your identification card or contact customer service at (800) 627-8797. If your identification card indicates "ERISA: Y" your plan is subject to ERISA.

These ERISA rules apply only to adverse benefit decisions. If you are enrolled in a plan provided by your Employer that is subject to ERISA, the rules outlined below will apply to adverse benefit decisions, but not to any other type of dispute you may have with us.

If you are enrolled in a plan provided by your Employer that is **not** subject to ERISA, the rules outlined below will **not** apply to you. For any grievance or dispute, please see the Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION."

URGENT CARE (when care has not yet been received)

Under ERISA, a claim involving urgent care is defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Insured. A preservice claim is any request for medical benefits that requires Preservice Review.

Note: All hours/days referred to are defined as calendar hours/days.

When you submit a request for benefits:

- We must notify you within seventy-two (72) hours of receipt of your request for benefits as to what we determine your benefits to be.
- If your request for benefits does not contain all the necessary information, we must notify you within twenty-four (24) hours of receipt of your request as to what information is needed to make a determination on your request.
- Any notice to you by us will be by telephone or in writing by facsimile or other rapid means.
- You have forty-eight (48) hours from receipt of this notice to provide to us the information needed to make a determination on your request for benefits. You may submit this information either by telephone or in writing by facsimile or other rapid means.

If your request for benefits is denied in whole or in part:

- We must provide written notice of the adverse benefit determination to you within seventy-two (72) hours after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the adverse benefit determination was made.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your request for benefits to appeal our decision. You may submit an appeal of the adverse benefit decision either by telephone or in writing by facsimile or other rapid means.
- Within seventy-two (72) hours of receipt of your appeal, we must notify you, either by telephone or in writing by facsimile or other rapid means, of our decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under the Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION."

NON-URGENT CARE – PRESERVICE (when care has not yet been received)

Note: Any claim that does not meet the above-stated criteria for urgent care is considered to be a non-urgent care claim. A preservice claim is any request for medical benefits that requires Preservice Review.

Note: All days referred to are defined as calendar days.

When you submit a request for benefits:

- We must notify you within fifteen (15) days of receipt of your request for benefits as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial fifteen (15) day period of the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may we take more than thirty (30) days to make a determination on your request for benefits.
- If your request for benefits does not contain all the necessary information, we must notify you in writing within five (5) days of receipt of your request as to what information is needed to make a determination on your request.
- You have forty-five (45) days from receipt of this notice to provide to us the information needed to make a determination on your request for benefits.

If your request for benefits is denied in whole or in part:

- We must provide written notice of the adverse benefit decision to you within fifteen (15) days after receiving all the information needed to make a determination on your request for benefits. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial is based. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial 15-day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your request for benefits to appeal our decision. You must submit your appeal in writing.
- Within thirty (30) days of receipt of your written appeal, we must notify you in writing of our decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under the Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION."

CONCURRENT CARE DECISIONS

If, after approving a request for benefits in connection with your illness, injury, disease or other condition, Anthem Blue Cross Life and Health decides to reduce or end these benefits, in whole or in part:

- We must notify you sufficiently in advance of the reduction in, or end of, benefits to allow you the opportunity to appeal our decision before the reduction in, or end of, benefits occurs. This notice will explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
- To keep the benefits previously approved, you must successfully appeal our decision to reduce or end those benefits. You must make your appeal to us at least twenty-four (24) hours prior to the reduction in, or end of, benefits.
- If you appeal the decision to reduce or end your benefits less than twenty-four (24) hours prior to the reduction in, or end of, benefits, your appeal will be treated as if you were appealing an urgent care adverse benefit decision (see the section entitled "URGENT CARE," above).
- If we receive your appeal for benefits at least twenty-four (24) hours prior to the reduction in, or end of, benefits, we must notify you of our decision regarding your appeal within twenty-four (24) hours of receipt of the appeal. If we deny your appeal of the decision to reduce or end your benefits, in whole or in part, we must explain the reason for the adverse benefit decision and the plan provisions upon which the decision was based.
- You may further appeal the adverse benefit decision according to the rules for appeal of an urgent care adverse benefit decision (see the section entitled "URGENT CARE," above).

NON-URGENT CARE – POST SERVICE (after care has been received)

Note: Under ERISA rules, a post-service claim is not considered to be an urgent care claim.

Note: All days referred to are defined as calendar days.

When you submit a claim:

- We must notify you in writing within thirty (30) days of receipt of your claim as to what we determine your benefits to be. This period may be extended one time for up to fifteen (15) days provided we determine that an extension is necessary due to matters beyond our control, and notify you prior to the expiration of the initial thirty (30) day period as to the circumstances requiring the extension of time and the date by which we expect to render a decision.
- In no case may we take more than forty-five (45) days to make a determination on your claim.
- If your claim does not contain all the necessary information, we must notify you in writing within thirty (30) days of receipt of your claim as to what information is needed to make a determination on your claim.
- You have forty-five (45) days from receipt of this notice to provide to us the information needed to make a determination on your claim.

If your claim is denied in whole or in part:

- We must provide written notice of the adverse benefit decision to you within thirty (30) days after receiving all the information needed to make a determination on your claim. The notice will explain the reason for the adverse benefit decision and the plan provisions upon which the denial decision is based.
- You have one hundred eighty (180) days from receipt of our adverse benefit decision on your claim to appeal our decision. You must submit your appeal in writing to us.
- Within thirty (30) days of receipt of your written appeal, we must notify you in writing of our decision on your appeal.
- If your appeal does not result in a reversal of the adverse benefit decision, you may pursue additional voluntary appeals, including those outlined under the Parts entitled "INDEPENDENT MEDICAL REVIEW OF GRIEVANCES" and "BINDING ARBITRATION."

Note: You, your beneficiary, or a duly authorized representative may appeal any adverse benefit decision on a claim for benefits with us and request a review of the adverse benefit decision. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge, and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

PART XI INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If an Insured has had any Covered Service denied, modified or delayed, or has had coverage denied because proposed treatment is determined by us to be Experimental or Investigational, or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external, independent medical review ("IMR") organization. To request a review, call us toll free at (800) 627-8797 or you may write us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9086, Oxnard, CA 93031-9086. To request an Independent Medical Review (IMR) from the California Department of Insurance (CDI), all of the following conditions must be satisfied:

For denials, modifications or delays based on a determination that a service is Experimental or Investigational:

1. The Insured must have a life-threatening or seriously debilitating condition.
    a. 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.
    b. A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
2. The proposed treatment must be recommended by a Participating Physician, or a board certified or board eligible Physician qualified to treat the Insured, who has certified in writing that it is more likely to be beneficial than standard treatment, and who has provided the supporting evidence.
3. If external, independent medical review is requested by the Insured or by a qualified Non-Participating Physician, as described above, the requester must supply two items of acceptable medical and scientific evidence, defined as follows:

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in or accepted for publication by medical journals that meet national recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act;
- Either of the following reference compendia: The American Hospital Formulary Service's-Drug Information or the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology.
    - The National Comprehensive Cancer Network Drug and Biologics Compendium.
    - The Thomson Micromedex DrugDex.
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

For denials, modifications or delays based on a determination that a service is not Medically Necessary:

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

1. a. Your provider has recommended a health care service as Medically Necessary,
   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 CDI's attention. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

General:

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

Within three (3) business days of our receipt from the California Department of Insurance of a request by a qualified Insured for an independent medical review, we or your Participating Providers will give the IMR organization designated by the Department a copy of all relevant medical records and documents for review, and any information submitted by the Insured or the Insured's Physician. Any subsequent information received will be forwarded to the IMR organization within three (3) business days. Additionally, any newly developed or discovered relevant medical records identified by us or our Participating Providers after the initial documents are provided will immediately be forwarded to the IMR 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.

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

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

For more information regarding the IMR process, or to request an application form, please call (800) 627-8797.

PART XII BINDING ARBITRATION

<u>ALL</u> DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. It is understood that any dispute including disputes relating to the delivery of services under the plan/Policy or any other issues related to the plan/Policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AND/OR ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR <u>BOTH</u> DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY 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 Insured making written demand on Anthem Blue Cross Life and Health and/or 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 Insured and Anthem Blue Cross Life and Health and/or Anthem Blue Cross, or by order of the court, if the Insured and Anthem Blue Cross Life and Health and/or Anthem Blue Cross cannot agree.

Should damages claimed be $50,000 or less, the arbitration shall be held by a single, neutral arbitrator mutually agreed to by the parties. Such arbitrator shall have no jurisdiction to award more than $50,000. The arbitrator shall be selected in accordance with the applicable rules of the arbitration administration entity. With respect to an arbitration held in California, if the parties are unable to agree on the selection of an arbitrator using the rules of the arbitration administration entity, the method provided in Code of Civil Procedure Section 1281.6 shall be used.

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 which the parties have agreed, in which cases, we will assume all or a portion of the Insured's costs of the arbitration. Unless you, Anthem Blue Cross Life and Health Insurance Company and/or Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. Anthem Blue Cross Life and Health and/or Anthem Blue Cross will provide Insureds, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all binding arbitration demands in writing to:

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

COMPLAINTS

If you have a complaint about services from Anthem Blue Cross Life and Health or your health care provider, including complaints regarding the ability to access needed health care in a timely manner, please call Anthem Blue Cross Life and Health toll free at (800) 627-8797 or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 60007, Los Angeles, CA 90060-0007.

If you have any questions regarding your eligibility or membership, please feel free to contact our customer service department toll free at (800) 627-8797, or you may write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA 93031-9062.

CALIFORNIA DEPARTMENT OF INSURANCE (CDI)

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

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

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

PART XIII THIRD PARTY LIABILITY

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

A. 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 Certificate for treatment of the illness, injury, disease, 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. 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. If you did not engage an attorney to gain your recovery from the third party, 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.

B. 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 the Policy. 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 the Policy. In the event of such material breach, you will be personally responsible and liable for reimbursing to us the amount of benefits we paid.

C. We will be entitled to collect on our lien even if the amount recovered by or for the Insured (or his or her estate, parent or legal guardian) from or for the account of such third party as compensation for the illness, injury, disease or condition is less than the actual loss suffered by the Insured.

PART XIV COORDINATION OF BENEFITS

If you are covered by more than one group health plan or dental plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans so that the benefits and services you receive from all group coverages do not exceed 100% of the Covered Expense. These coordination provisions apply separately to each Insured, per calendar Year, and are largely determined by California law. Any coverage you have for medical or dental benefits will be coordinated as described throughout this Part XIV.

DEFINITIONS

The meanings of key terms used in this section are listed below. Whenever any of these key terms appears in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Definitions" provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining our payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which we would determine to be eligible expense if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expense in the absence of other coverage.

Other Plan is any of the following:

1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of Other Plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.

This Plan is that portion of This Plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision.

2. A plan which covers you as a Certificateholder pays before a plan which covers you as a Dependent. But, if you are a Medicare beneficiary and also a Dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare's rules, Medicare pays after that plan which covers you as a Dependent, then the plan which covers you as a Dependent pays before a plan which covers you as a Certificateholder.

   For example: You are covered as a retired Certificateholder under This Plan and a Medicare beneficiary (Medicare would pay first; This Plan would pay second). You are also covered as a Dependent of an active employee under another plan provided by an employer group of twenty (20) or more employees (then, according to Medicare's rules, Medicare would pay second). In this situation, the plan which covers you as a Dependent of an active employee will pay first and the plan which covers you as a retired Certificateholder will pay last, after Medicare.

3. For a dependent Child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar Year pays before the plan of the parent whose birthday falls later in the calendar Year. But, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

   Exception to rule 3: For a Dependent Child of parents who are divorced or separated, the following rules will be used in place of rule 3:

   a. If the parent with custody of that Child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that Child as a Dependent pays first.

   b. If the parent with custody of that Child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:

      i. The plan which covers that Child as a Dependent of the parent with custody.
      ii. The plan which covers that Child as a Dependent of the stepparent (married to the parent with custody).
      iii. The plan which covers that Child as a Dependent of the parent without custody.
      iv. The plan which covers that Child as a Dependent of the stepparent (married to the parent without custody).

   c. Regardless of a. and b. above, if there is a court decree which establishes a parent's financial responsibility for that Child's health care coverage, a plan which covers that Child as a Dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a Dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the Dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6. applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays last. If the order of benefit determination provisions of the Other Plan does not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

OUR RIGHTS UNDER THIS PROVISION

Responsibility for Timely Notice. We are not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and our liability will be reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, we have the right to pay that Other Plan any amount we determine to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy our liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, we have the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.

PART XV EXTENSION OF BENEFITS

A. If an Insured is Totally Disabled when coverage ends and is under the treatment of a Physician, the benefits of this Certificate will continue to be provided for services treating the totally disabling illness, injury, or condition. No benefits are provided for services treating any other illness, injury or condition.

B. An Insured confined as an inpatient in a Hospital or Skilled Nursing Facility is considered Totally Disabled as long as the inpatient stay is Medically Necessary, and no written certification of the total disability is required. Benefits of this Certificate will continue until an Insured is discharged or transferred to a lesser level of care facility.

C. An Insured who was not confined as an inpatient, is no longer confined as an inpatient, or is transferred to a lesser level of care as stated in paragraph B above, and who wishes to apply for total disability benefits, must submit written certification by the Physician of the total disability and we may require the submission of medical records and/or a statement from Social Security. We must receive this certification within ninety (90) days of the date coverage ends under the Policy. At least once every ninety (90) days while benefits are extended, we must receive proof that the Insured's total disability is continuing.

D. Benefits are provided until one of the following occurs:

1. The Insured is no longer Totally Disabled, or
2. The maximum benefits of the Policy are paid, or
3. The Insured becomes covered under group health coverage that provides coverage without limitation for the disabling illness or injury, or
4. A period of twelve (12) consecutive months has passed since the date coverage has ended, or
5. If the Insured or any representative for the Insured fails to notify Anthem Blue Cross Life and Health of the continuing disability at the end of any of the ninety (90) day intervals, the extension will automatically terminate. Notification is the responsibility of the Insured or a representative who may be appointed by the Insured.

PART XVI CONVERSION

When your coverage under the Certificate ends, you may apply to Anthem Blue Cross Life and Health within sixty-three (63) days for a conversion plan. THE TERMS, BENEFITS AND PREMIUMS OF THE CONVERSION PLAN ARE DIFFERENT THAN THOSE OF THE POLICY. Application for conversion membership does not require a health statement. Conversion membership is not available if:

- The Policy terminated or the Employer's participation terminated and the Policy is replaced by similar coverage under another group policy within fifteen (15) days of the date of termination of the Policy or the Insured's participation or
- The Insured's coverage under this Certificate ends because of failure to pay premiums, or
- The Insured is eligible for group health coverage when coverage under this Certificate ends, or
- The Insured is eligible for Medicare coverage when coverage under this Certificate ends, whether or not the Insured has actually enrolled in Medicare, or
- The Insured is covered under any individual health plan when coverage under this Certificate ends, or
- The Insured is terminated by us for good cause, or
- The Insured knowingly furnished incorrect information or otherwise improperly obtained the benefits of the plan, or
- The Insured has not been continuously covered during the three-month period immediately preceding their termination of coverage.

PART XVII CONTINUATION OF COVERAGE CAL-COBRA

If the Group is an Employer with two (2) to nineteen (19) full-time, permanent, active employees on a typical business day, you may be entitled, in accordance with the provisions of this Part, to continue for a limited period of time coverage that would otherwise end. In order to continue coverage, you must meet certain qualifications, and you and the Group must also satisfy certain requirements, according to the provisions set forth throughout this Part XVII.

DEFINITIONS

The meanings of key terms used in this section are listed below. Whenever any of the key terms appears in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the TERMS OF CAL-COBRA CONTINUATION provisions in this Part XVII.

Qualified Beneficiary means: (a) a person enrolled for this Cal-COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Certificate as either a Certificateholder or Dependent, (b) a Child who is born to or placed for adoption with the Certificateholder during the Cal-COBRA continuation period, or (c) a Child for whom the Certificateholder or Spouse has been appointed permanent legal guardian by final court decree or order during the Cal-COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any Dependents acquired during the Cal-COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the Policy. The event will be referred to throughout this section by letter/number.

A. **For Certificateholders and Dependents:**

1. The Certificateholder's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Certificateholder's work hours.

B. **For Dependents:**

1. The death of the Certificateholder;
2. The Spouse's divorce or legal separation from the Certificateholder;
3. The end of a Child's status as a dependent Child, as defined by this Certificate;
4. The Certificateholder's entitlement to Medicare; or
5. The loss of eligible status by an enrolled Dependent.

ELIGIBILITY FOR CAL-COBRA CONTINUATION

A Certificateholder or Dependent may choose to continue coverage under the Certificate if his or her coverage would otherwise end due to a Qualifying Event.

Exception: An Insured is not entitled to continue coverage if, at any time of the Qualifying Event: (1) the Insured is entitled to Medicare; (2) the Insured is covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured; (3) we fail to receive timely notice of the Qualifying Event or election of a Cal-COBRA continuation (please see TERMS OF CAL-COBRA CONTINUATION); (4) the Insured fails to submit the required premiums; (5) the Insured is covered, becomes covered, or is eligible for federal COBRA; or (6) the Insured is covered, becomes covered, or is eligible for coverage pursuant to Chapter 6A of the Public Health Service Act, 29 U.S.C. Section 1161 et seq. If one Insured is unable to continue coverage for these reasons, other entitled Insureds may still choose to continue their coverage.

TERMS OF CAL-COBRA CONTINUATION

1. For Qualifying Event A. above, the Group must notify the Certificateholder and us within thirty (30) days of the Qualifying Event of the right to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

2. You must inform us within sixty (60) days of Qualifying Event B. above if you wish to continue coverage. We in turn must within fourteen (14) days give you official notice of the Cal-COBRA continuation right.

If you choose to continue coverage, you must notify us within sixty (60) days of the later of: (i) the date your coverage under the Policy terminates by reason of a Qualifying Event, or (ii) the date you were sent notice of your Cal-COBRA continuation right. The Cal-COBRA continuation coverage may be chosen for all Insureds within a covered family, or only for selected Insureds.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

If you fail to elect the Cal-COBRA continuation during the Initial Enrollment Period, you may not elect the Cal-COBRA continuation at a later date.

The initial premiums must be delivered to us within forty-five (45) days after you elect Cal-COBRA continuation coverage.

An election of continuation coverage must be in writing and delivered to us by first class mail or other reliable means of delivery, including personal delivery, express mail or private courier company. The initial premiums must be delivered to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9062, Oxnard, CA 93031-9062 by first class mail, certified mail or other reliable means of delivery, including personal delivery, express mail or private courier company, and must be in an amount sufficient to pay all premiums due. **A failure to properly give notice of an election of continuation coverage or a failure to properly and timely pay premiums due will disqualify you from continuing coverage under this Part.**

If you have Cal-COBRA continuation coverage under a prior plan that terminates because the policy between the employer and the prior plan terminates, you may elect continuation coverage under the Policy, which will continue for the balance of the period under which you would have remained covered under the prior plan. To do so, you must make the election and pay all premiums on the terms described above and below. Such continuation coverage will terminate if you fail to comply with the requirements for enrolling in and paying premiums to us within thirty (30) days of receiving notice of the termination of the prior plan.

Additional Dependents. A Child acquired during the Cal-COBRA continuation period is eligible to be enrolled as a Dependent and has separate rights as a Qualified Beneficiary. The standard enrollment provisions of the Certificate apply to enrollees during the Cal-COBRA continuation period. A Dependent acquired and enrolled after the effective date of continuation coverage resulting from the original Qualifying Event is not eligible for a separate continuation if a subsequent Qualifying Event results in the person's loss of coverage.

Cost of Coverage. You must pay us the premium required under the Policy for your Cal-COBRA continuation coverage, and the notice of your Cal-COBRA continuation right, which you will receive from us, will include the amount of the required premium payment. This cost, called the "premium," must be remitted to us by the first of each month during the Cal-COBRA continuation period and shall be 110% of the rate applicable to an Insured for whom a Qualifying Event has not occurred. The first payment of the premium is due within forty-five (45) days after you elect Cal-COBRA. **We must receive subsequent payments of the premium from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the Certificateholder, the Certificateholder's rate also applies to:

1. A Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Certificateholder;

2. A Child if neither the Certificateholder nor the Spouse has enrolled for this Cal-COBRA continuation coverage (if more than one Child is so enrolled, the premium will be based on the two-party or three-party rate depending on the number of children enrolled); and

3. A Child whose Cal-COBRA continuation began due to the person no longer meeting the dependent Child definition.

Subsequent Qualifying Events. Once covered under the Cal-COBRA continuation, it is possible for a second Qualifying Event to occur. If that happens, an Insured who is a Qualified Beneficiary may be entitled to an extended Cal-COBRA continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first Qualifying Event.

For example, a Child may have been originally eligible for Cal-COBRA continuation due to termination of the Certificateholder's employment, and enrolled for this Cal-COBRA continuation as a Qualified Beneficiary. If, during the Cal-COBRA continuation period, the Child reaches the upper age limit of the plan, the Child is eligible to remain covered for the balance of the continuation period, which would end no later than thirty-six (36) months from the date of the original Qualifying Event (the termination of employment).

When Cal-COBRA Continuation Coverage Begins. When Cal-COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For Dependents properly enrolled during the Cal-COBRA continuation, coverage begins according to the enrollment provisions of the Policy.

When Cal-COBRA Continuation Ends.

For Insureds beginning Cal-COBRA continuation coverage effective on or after January 1, 2003, this continuation will end on the earliest of:

1. The end of thirty-six (36) months from the Qualifying Event;*
2. The date the Certificate terminates;
3. The end of the period for which premiums are last paid;
4. The date the Insured becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured, in which case this Cal-COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;
5. In the case of (a) a Certificateholder who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Certificateholder's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Certificateholder is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Certificateholder is no longer disabled;
6. The date the Insured becomes entitled to Medicare;
7. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
8. The date the Insured moves out of the plan's service area or commits fraud or deception in the use of services.

*For an Insured whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation under this plan ends in accordance with items 1. or 2. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

For Insureds beginning Cal-COBRA continuation coverage effective prior to January 1, 2003, this continuation will end on the earliest of:

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
   Note: The eighteen (18) months may be extended for up to twenty-nine (29) months for total disability as determined by the Social Security Administration.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the Certificateholder, divorce or legal separation, or the end of Dependent status;*
3. For a Dependent, the end of thirty-six (36) months from the date the Certificateholder became entitled to Medicare, if the Qualifying Event was the Certificateholder's entitlement to Medicare;
4. The date the Certificate terminates;
5. The end of the period for which premiums are last paid;
6. The date the Insured becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured, in which case this Cal-COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;
7. In the case of (a) a Certificateholder who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Certificateholder's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage, and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of eighteen (18) months from the Qualifying Event. If the Certificateholder is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of eighteen (18) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Certificateholder is no longer disabled;
8. The date the Insured becomes entitled to Medicare;
9. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the Insured moves out of the plan's service area or commits fraud or deception in the use of services.

*For an Insured whose Cal-COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

If your Cal-COBRA continuation under this plan ends in accordance with items 1., 2., 3. or 4. above, you are eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

Note: This section (EXTENSION OF CONTINUATION DURING TOTAL DISABILITY) applies only to Insureds who began Cal-COBRA continuation coverage effective prior to January 1, 2003.

If, at the time of termination of employment or reduction in hours or at any time during the first sixty (60) days of a Cal-COBRA continuation, a Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered Insureds may be entitled to up to twenty-nine (29) months of continuation coverage after the original Qualifying Event. The Insured must furnish us with written notice within thirty (30) days of the Social Security Administration's decision that the Insured is no longer Totally Disabled.

Eligibility for Extension. To continue coverage for up to twenty-nine (29) months from the date of the original Qualifying Event, the disabled Insured must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and

2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The Insured must furnish us with proof of the Social Security Administration's determination of disability during the first eighteen (18) months of the Cal-COBRA continuation period and no later than sixty (60) days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the nineteenth (19th) through the twenty-ninth (29th) months that the total disability continues, you must remit to us the cost for extended continuation coverage. This cost (called the "premium") shall be subject to the following conditions:

1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by you by the first of each month during the period of extended continuation coverage.
2. We must receive the premium from you by the first of each month in order to maintain the extended continuation coverage in force.

When the Extension Ends. This extension will end at the earliest of:

1. The end of the month following a period of thirty (30) days after the Social Security Administration's final determination that you are no longer Totally Disabled;
2. The end of a period of twenty-nine (29) months from the Qualifying Event;
3. The date the Certificate terminates;
4. The end of the period for which premiums are last paid;
5. The date the Insured becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured, in which case this Cal-COBRA extension will end at the end of the period for which the Preexisting Condition exclusion or limitation applied;

6. In the case of (a) a Certificateholder who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Certificateholder's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Certificateholder is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Certificateholder is no longer disabled;
7. The date the Insured becomes entitled to Medicare;
8. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
9. The date the Insured moves out of the plan's service area or commits fraud or deception in the use of services.

You must inform us within thirty (30) days of a final determination by the Social Security Administration that you are no longer Totally Disabled.

POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER

Note: This section (POST CAL-COBRA CONTINUATION OF COVERAGE FOR QUALIFYING EVENTS OCCURRING FOR AGES 60 AND OVER) applies ONLY when Certificateholders turn sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums stated in the Policy, coverage under the Policy may be continued for the Certificateholder, the Certificateholder's Spouse and the Certificateholder's former Spouse (if any) under Section 10116.5 of the Insurance Code, in accordance with the following provisions. This continuation may be elected following the CAL-COBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former Spouse" means: (a) an individual who is divorced from the Certificateholder; or (b) an individual who was married to the Certificateholder at the time of the Certificateholder's death.

Requirements: The Certificateholder, Spouse and former Spouse may continue coverage under the Policy if:

A. The Certificateholder, or the Certificateholder on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under, Cal-COBRA as described in the preceding section;
B. The Certificateholder or Spouse has not elected to continue coverage under any other available continuation;
C. The Certificateholder has worked for the Employer for at least five (5) years prior to termination of employment; and
D. The Certificateholder is at least sixty (60) years old on the date employment with the Group ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a Qualified Beneficiary under Cal-COBRA.

TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE

Note: This section (TERMS OF CAL-COBRA EXTENSION OF CONTINUATION OF COVERAGE) applies ONLY when Certificateholders turn sixty (60) years of age prior to January 1, 2005.

Notice and Election. We will notify you and your Spouse or former Spouse of the right to an extension in your continuation of coverage at least ninety (90) days prior to the date continuation of coverage under Cal-COBRA is scheduled to end.

If you choose to continue coverage, you must notify us in writing within thirty (30) days prior to the end of your Cal-COBRA continuation period.

If you fail to elect the extended Cal-COBRA continuation during the Post Cal-COBRA election period, you may not elect the Cal-COBRA continuation at a later date.

Cost of Coverage. You must pay us the premium required under the Policy for your Cal-COBRA extended coverage, and the notice of your Cal-COBRA extended coverage right, which you will receive from us, will include the amount of the required premium payment. This cost, called the "premium," must be remitted to us by the first of each month during the Cal-COBRA extended continuation period and shall be 110% of the rate applicable to an Insured for whom a Qualifying Event has not occurred. **We must receive payment of the premium from you by the first of each month in order to maintain the coverage in force.**

Besides applying to the Certificateholder, the Certificateholder's rate also applies to a Spouse or former Spouse whose Cal-COBRA continuation began due to divorce, separation or death of the Certificateholder.

When Post Cal-COBRA Continuation Ends. This continuation will end on the earliest of:

1. The date the Certificate terminates;
2. The end of the period for which premiums are last paid;
3. The date the Insured becomes covered under any other group health coverage;
4. The date the Insured becomes eligible for Medicare;
5. For a Spouse or former Spouse of the Certificateholder, five (5) years from the date on which continuation coverage under Cal-COBRA was scheduled to end for the Certificateholder;
6. In the case of (a) a Certificateholder who is eligible for continuation coverage because of the termination of employment or reduction in hours of the Certificateholder's employment (except for gross misconduct) and determined, under Title II or Title XVI of the Social Security Act, to be disabled at any time during the first sixty (60) days of continuation coverage and (b) his or her Spouse or dependent Child who has elected Cal-COBRA coverage, the end of thirty-six (36) months from the Qualifying Event. If the Certificateholder is no longer disabled under Title II or Title XVI, benefits shall terminate on the later of thirty-six (36) months from the Qualifying Event or the month that begins more than thirty-one (31) days after the date of the final determination under Title II or Title XVI that the Certificateholder is no longer disabled;

7. The date on which the Employer or former employer terminates its Policy with the health care services plan and no longer provides coverage for any active employees through the plan;
8. The date the Insured reaches the age of sixty-five 65;
9. The date the Employer, or any successor employer or purchaser of the Employer, ceases to provide any group benefit plan to his or her employees; or
10. The date the Insured moves out of the plan's service area or commits fraud or deception in the use of services.

If your Cal-COBRA continuation under this plan ends in accordance with items 1. or 5. above, you may be eligible for medical conversion coverage. We must provide notice of this conversion right within 180 days prior to such termination date.

If your Cal-COBRA continuation coverage under this plan ends because the Group replaces our coverage with coverage from another company, the Group must notify you at least thirty (30) days in advance and let you know what you have to do to enroll for coverage under the new plan for the balance of your Cal-COBRA continuation period.

PART XVIII CONTINUATION OF COVERAGE COBRA

Most employers who employ twenty (20) or more people on a typical business day are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If the Employer who provides coverage under the Certificate is subject to the federal law which governs this provision (Title X of P.L. 99-272), you may be entitled to continuation of coverage. Check with your Employer for details.

DEFINITIONS

The meanings of key terms used in this section are listed below. Whenever any of the key terms appears in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this "Definitions" provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the TERMS OF COBRA CONTINUATION provisions.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this Certificate as either a Certificateholder or Dependent, (b) a Child who is born to or placed for adoption with the Certificateholder during the COBRA continuation period, or (c) a Child for whom the Certificateholder or Spouse has been appointed permanent legal guardian by final court decree or order during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any Dependents acquired during the COBRA continuation period, with the exception of newborns, adoptees, and children of permanent legal guardians as specified above.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the Policy. The event will be referred to throughout this section by letter/number.

A. **For Certificateholder and Dependents:**

1. The Certificateholder's termination of employment, for any reason other than gross misconduct; or
2. A reduction in the Certificateholder's work hours.

B. **For Retired Employees and their Dependents.** Cancellation or a substantial reduction of retiree benefits under the plan due to the Group's filing for Chapter 11 bankruptcy, provided that:

1. The Policy expressly includes coverage for retirees; and
2. Such cancellation or reduction of benefits occurs within one year before or after the Group's filing for bankruptcy.

C. **For Dependents:**

1. The death of the Certificateholder;
2. The Spouse's divorce or legal separation from the Certificateholder;
3. The end of a Child's status as a dependent Child, as defined by this Certificate; or
4. The Certificateholder's entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A Certificateholder or Dependent may choose to continue coverage under the Certificate if his or her coverage would otherwise end for a Qualifying Event.

Exception: An Insured is not entitled to continue coverage if, at any time of the Qualifying Event, that Insured is: 1) entitled to Medicare*; or 2) covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured. If one Insured is unable to continue coverage for these reasons, other entitled Insureds may still choose to continue their coverage.

*Entitlement to Medicare will not preclude a person from continuing coverage for which the person became eligible due to Qualifying Event B.

TERMS OF COBRA CONTINUATION

Notice. The Group or its administrator (we are not the administrator) will notify either the Certificateholder or Dependent of the right to continue coverage under COBRA, as follows:

1. For Qualifying Events A. or B. above, the Group or its administrator will notify the Certificateholder of the right to continue coverage.

2. For Qualifying Events C (1) or C (4) above, a Dependent will be notified of the COBRA continuation right.

3. You must inform the Group within sixty (60) days of Qualifying Events C (2) or C (3) above if you wish to continue coverage. The Group in turn will promptly give you official notice of the COBRA continuation right.

If you choose to continue coverage you must notify the Group within sixty (60) days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all Insureds within a family, or only for selected Insureds.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial premium, must be delivered to us by the Group within forty-five (45) days after you elect COBRA continuation coverage.

Additional Dependents. A Spouse or Child acquired during the COBRA continuation period is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Certificate apply to enrollees during the COBRA continuation period.

Cost of Coverage. The Group may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the “premium,” must be remitted to the Group by the first of each month during the COBRA continuation period. We must receive payment of the premium from the Group by the first of each month in order to maintain the coverage in force.

Besides applying to the Certificateholder, the Certificateholder's rate also applies to:

1. A Spouse whose COBRA continuation began due to divorce, separation or death of the Certificateholder;
2. A Child if neither the Certificateholder nor the Spouse has enrolled for this COBRA continuation coverage (if more than one Child is so enrolled, the premium will be the two-party or three-party rate depending on the number of children enrolled); and
3. A Child whose COBRA continuation began due to the person no longer meeting the dependent Child definition.

Subsequent Qualifying Events. Once covered under the COBRA continuation, it's possible for a second Qualifying Event to occur. If that happens, an Insured who is a Qualified Beneficiary may be entitled to an extended COBRA continuation period. This period will in no event continue beyond thirty-six (36) months from the date of the first Qualifying Event.

For example, a Child may have been originally eligible for COBRA continuation due to termination of the Certificateholder's employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the Child reaches the upper age limit of the plan, the Child is eligible to remain covered for the balance of the continuation period which would end no later than thirty-six (36) months from the date of the original Qualifying Event (the termination of employment).

When COBRA Continuation Coverage Begins. When COBRA continuation coverage is elected during the Initial Enrollment Period and the premium is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For Dependents properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the Policy.

When COBRA Continuation Ends. This continuation will end on the earliest of:

1. The end of eighteen (18) months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours;*
   Note: (For Insureds beginning COBRA continuation coverage effective January 1, 2003 or later ONLY.) At the end of eighteen (18) months, you have the option to continue coverage under Cal-COBRA for the balance of thirty-six (36) months (COBRA and Cal-COBRA combined). All COBRA eligibility must be exhausted before the Insured is eligible to continue coverage under Cal-COBRA.
2. The end of thirty-six (36) months from the Qualifying Event, if the Qualifying Event was the death of the Certificateholder, divorce or legal separation, or the end of dependent Child status;*
3. The end of thirty-six (36) months from the date the Certificateholder became entitled to Medicare, if the Qualifying Event was the Certificateholder's entitlement to Medicare;
4. The date the Policy terminates;
5. The end of the period for which premiums are last paid;

6. The date the Insured becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured, in which case this COBRA continuation will end at the end of the period for which the Preexisting Condition exclusion or limitation applied; or
7. The date the Insured becomes eligible for Medicare.

*For an Insured whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan.

Subject to the Policy remaining in effect, a retired Certificateholder whose COBRA continuation coverage began due to Qualifying Event B. may be covered for the remainder of his or her life; that person's covered Dependents may continue coverage for thirty-six (36) months after the Certificateholder's death. But, coverage could terminate prior to such time for either the Certificateholder or Dependent in accordance with items 4., 5. or 6. above.

If your COBRA continuation under this plan ends in accordance with items 1. or 2., you are eligible for medical conversion coverage. The Group will provide notice of this conversion right within 180 days prior to such termination date.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA, the Qualified Beneficiary is determined to be disabled for Social Security purposes, all covered Insureds may be entitled to up to twenty-nine (29) months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to twenty-nine (29) months from the date of the original Qualifying Event, the disabled Insured must:

1. Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and
2. Be determined and certified to be so disabled by the Social Security Administration.

Notice. The Insured must furnish the Group with proof of the Social Security Administration's determination of disability during the first eighteen (18) months of the COBRA continuation period and no later than sixty (60) days after the date of the Social Security Administration's determination of such disability.

Cost of Coverage. For the nineteenth (19^{th}) through the twenty-ninth (29^{th}) months that the total disability continues, the Group must remit to us the cost for extended continuation coverage. This cost (called the "premium") shall be subject to the following conditions:

1. This charge shall be 150% of the applicable rate, depending upon the number of persons covered, and must be remitted to us by the Group by the first of each month during the period of extended continuation coverage.
2. The Group may require that you pay the entire cost of the extended continuation coverage.
3. We must receive timely payment of the premium from the Group by the first of each month in order to maintain the extended continuation coverage in force.

When the Extension Ends. This extension will end at the earliest of:

1. The end of the month following a period of thirty (30) days after the Social Security Administration's final determination that you are no longer Totally Disabled;
2. The end of twenty-nine (29) months from the Qualifying Event;
   Note: (For Insureds beginning COBRA continuation coverage effective January 1, 2003 or later ONLY.) At the end of twenty-nine (29) months, you have the option to continue coverage under Cal-COBRA for the balance of thirty-six (36) months (COBRA and Cal-COBRA combined). All COBRA eligibility must be exhausted before the Insured is eligible to continue coverage under Cal-COBRA.
3. The date the Policy terminates;
4. The end of the period for which premiums are last paid;
5. The date the Insured becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a Preexisting Condition of the Insured, in which case this COBRA extension will end at the end of the period for which the Preexisting Condition exclusion or limitation applied; or
6. The date the Insured becomes entitled to Medicare.

You must inform the Group within thirty (30) days of a final determination by the Social Security Administration that you are no longer Totally Disabled.

POST-COBRA CONTINUATION FOR QUALIFYING INSUREDS

Note: This section (POST COBRA CONTINUATION FOR QUALIFYING INSUREDS) applies ONLY when Certificateholders turn sixty (60) years of age prior to January 1, 2005.

Subject to payment of premiums as stated in the Policy, coverage under this plan may be continued for the Certificateholder, the Certificateholder's Spouse and the Certificateholder's former Spouse (if any) under Section 10116.5 of the Insurance Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272).

For the purposes of this section, "former Spouse" means: (a) an individual who is divorced from the Certificateholder; or (b) an individual who was married to the Certificateholder at the time of the Certificateholder's death.

Requirements. The Certificateholder and Spouse may continue coverage under this plan if:

A. The Certificateholder, or the Certificateholder on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under, COBRA as described in the preceding section;
B. The Certificateholder or Spouse has not elected to continue coverage under any other available continuation;
C. The Certificateholder has worked for the Employer for at least the prior five (5) years; and
D. The Certificateholder is at least sixty (60) years old on the date employment with the Group ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a Qualified Beneficiary under COBRA, as described in the preceding section.

Notice and Election. The Group or its administrator (we are not the administrator) will notify the Certificateholder or Spouse and former Spouse of the right to continue coverage at least ninety (90) days prior to the date continuation of coverage under COBRA is scheduled to end.

For the Certificateholder and Spouse, this continuation may be chosen for both, the Certificateholder only, or for the Spouse only. The former Spouse may elect this continuation for himself or herself only.

To elect this continuation, you must notify the Employer in writing within thirty (30) days prior to the date continuation coverage under COBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial premium, must be delivered to us by the Group within forty-five (45) days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of premiums to the Employer at the time the Group premium is due. The Group may require that you pay the entire cost of your continuation coverage. The Group is responsible to us for the timely payment of premiums due for the continuation of your coverage under the Policy.

The rates for continuation coverage under this section are as follows:

1. For the Certificateholder and Spouse, the rate shall be 102% of the applicable Group rate. For the purpose of determining premiums payable, the Spouse continuing coverage alone will be considered to be a Certificateholder.
2. For a former Spouse, the rate shall be 102% of the applicable Group rate.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which premiums are last paid;
2. The date this Certificate terminates;
3. The date the Certificateholder, Spouse or former Spouse becomes covered under any group health plan not maintained by the Employer;
4. The date the Certificateholder, Spouse or former Spouse becomes entitled to Medicare;
5. The date the Certificateholder, Spouse or former Spouse reaches age sixty-five (65); or
6. For the Spouse or former Spouse, five (5) years from the date the Spouse's or former Spouse's COBRA continuation coverage ended.

If your continuation under this plan ends in accordance with item 6., you are eligible for medical conversion coverage.

CONTINUATION FOR QUALIFYING DEPENDENTS

Subject to payment of premiums as stated in the Policy, coverage under this plan may be continued for enrolled Dependents of a Certificateholder in accordance with the following provisions. You may elect this continuation instead of, or following, the CONTINUATION OF COVERAGE shown above (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272). **However, for an eligible Spouse, this continuation may not be elected if the POST-COBRA CONTINUATION FOR QUALIFYING INSUREDS described in the previous section was elected.**

A. QUALIFYING EVENTS FOR CONTINUATION COVERAGE

Coverage may be continued by an eligible Dependent if that coverage would otherwise end because of:

1. The death of the Certificateholder,
2. Notice of the final decree of divorce, annulment or dissolution of marriage between the Certificateholder and the enrolled Spouse, or
3. The Certificateholder's entitlement to Medicare.

Eligible Dependents.

The following Dependents may continue coverage:

1. Surviving Spouse,
2. Divorced Spouse of the Certificateholder, and
3. Dependent Child (except a Child of a divorced Spouse of the Certificateholder who remains enrolled as a Dependent of that Certificateholder).

Note: Eligibility for coverage as a Dependent is determined according to the eligibility requirements described under the Part entitled "WHO IS COVERED AND WHEN."

B. TO ELECT THIS CONTINUATION

To elect this continuation, the Dependent (or guardian for a Child under age 18) must properly file an application within thirty (30) days from the Qualifying Event. An application is considered properly filed only if all requested information is supplied and the application is personally signed, dated, and given to the Group within thirty (30) days of the Qualifying Event. We must receive this application from the Group within ninety (90) days.

This continuation coverage may be chosen for all eligible Dependents, or only for selected Insureds. However, if the Insured fails to elect the continuation when first eligible, that Insured may not elect the continuation at a later date.

C. WHEN CONTINUATION ENDS

This continuation will end on the earliest of:

1. The end of the period for which premiums were last paid;
2. The date the Certificate terminates;
3. The end of ninety (90) days from the date the Dependent's continuation coverage began;
4. The date the Dependent moves outside California*;
5. The date the surviving or divorced Spouse remarries*;
6. The date the Dependent becomes eligible for any comparable state, federal or private group medical plan*;

7. The date the Dependent becomes eligible for coverage under an employer group health plan*;
8 The date a dependent Child is no longer eligible due to age*;
9. The date the Dependent knowingly furnishes incorrect information or otherwise improperly obtains benefits of the plan.
10. The date the Certificateholder or Spouse is no longer the permanent legal guardian.*

*This continuation coverage will not end for the other eligible Dependents if item 4., 6., 7., 8., or 10. above applies to a dependent Child.

D. **PAYMENT OF PREMIUMS**

The Group is responsible to Anthem Blue Cross Life and Health for the timely payment of premiums due for the continuation of any Insured's coverage under this plan. For purposes of determining premiums payable, the surviving or divorced Spouse will be considered to be a Certificateholder.

PART XIX GUARANTEED ACCESS TO COVERAGE FOR FEDERALLY ELIGIBLE DEFINED INDIVIDUALS

A disability insurer that offers hospital, medical or surgical benefits under an individual health benefit plan as defined in subdivision (a) of Section 10198.6 may not decline to offer coverage to, or deny enrollment of, a federally eligible defined individual or impose any Preexisting Condition with respect to the coverage. A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that if you lose group health coverage and meet the criteria below, you are entitled to purchase individual health coverage from any health care service plan or insurance company that sells individual coverage for hospital, medical or surgical benefits. A health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work within the plan's service area.

A federally eligible individual is an individual who, as of the date on which the individual seeks coverage under this provision, meets all of the following conditions:

1. Has had eighteen (18) or more months of Creditable Coverage without a break of sixty-three (63) days or more between any of the periods of Creditable Coverage or since the most recent coverage was terminated and whose most recent Creditable Coverage was under a group health plan (including Cal-COBRA or COBRA), a federal government plan maintained for federal employees, or a governmental plan or church plan as defined in the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1002), and
2. Is not eligible for coverage under a group health plan, Medicare, or Medi-Cal, and does not have any other health coverage, and
3. Was not terminated from his or her most recent Creditable Coverage due to nonpayment of premiums or fraud, and
4. If offered continuation coverage under COBRA or Cal-COBRA, has elected and exhausted that coverage.

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 on-site 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 Section 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)).

PART XX DEFINITIONS

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

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

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

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

- There is no Participating Physician who practices in the appropriate specialty, or there is no Participating Hospital, Participating Ambulatory Surgical Center or Participating Hospice which provides the required services or has the necessary facilities within the county in which the Insured lives, and
- The referral has been authorized by us ***before*** services are rendered.

Certificateholder is the employee of the Employer who has enrolled in this Certificate as the primary Insured (that is, not as a Dependent).

Child is the Certificateholder's, Spouse's or Domestic Partner's natural Child, stepchild, legally adopted Child, Child placed in the physical custody of the parent for legal adoption or Child for whom the Certificateholder, Spouse or Domestic Partner has been appointed permanent legal guardian by final court decree or order.

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

Copayment is the amount of Covered Expense you are responsible for paying. Copayment does not include charges for services that are not Covered Services or charges in excess of Covered Expense.

Cosmetic and Reconstructive Surgery. Cosmetic Surgery is surgery that is performed to alter or reshape normal structure of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate and is performed to correct or repair abnormal structure of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (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 Expense is the expense you incur for Covered Services, but for some services the amount of Covered Expense will be limited to a maximum amount that is described in the benefit sections of this Certificate.

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

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

Day Treatment Program Center 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 Covered Expense you must pay for Covered Services in a Year before any benefits are available to you under this Certificate. Your Deductible is stated in the Part entitled "ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS."

Dental Prostheses are dentures, crowns, caps, bridges, clasps, habit appliances and partials.

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

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

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

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

Domestic Partners (Domestic Partnership) are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. Further, they must have either filed a Declaration of Domestic Partnership with the Secretary of State of the state of California in accordance with Section 298.5 of the Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created. A Domestic Partner must meet the Policy's eligibility requirements for Domestic Partners outlined under the Part entitled "WHO IS COVERED AND WHEN."

Effective Date is the date on which your coverage under this Certificate begins.

Emergency Services, with respect to a Medical Emergency condition, means a medical screening examination (as required under federal law) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under federal law to Stabilize the patient.

Employer (Group) is the person, company, corporation, partnership or other entity (depending on the legal form of organization) which has entered into a contract with Anthem Blue Cross Life and Health Insurance Company to provide the benefits of this Certificate.

Employer Effective Date is the date this Certificate became effective under the terms of the Policy.

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

Facility Based Treatment for Mental or Nervous Disorders and Substance Abuse (Facility Based Treatment)is treatment rendered in, including, but not limited to, an acute psychiatric facility, Hospital, psychiatric health facility, residential treatment center, Day Treatment Program Center or intensive outpatient treatment center.

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

Guaranteed Association means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in state law, (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

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

Hospice is an agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A Hospice must be currently licensed as a Hospice according to state and local laws or a licensed Home Health Agency with federal Medicare certification. A list of Participating Hospices meeting these criteria is available upon request.

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

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

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

Host Blue is an independent licensee of the Blue Cross and Blue Shield Association that participates in the Association's BlueCard Program, which allows our Insureds to have the reciprocal use of participating providers that contract with other Blue Cross and/or Blue Shield plans. If you are outside California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider that has an agreement with the Host 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.

Infertility is the inability to:

- conceive after sexual relations without contraceptives for the period of one year; or
- maintain a pregnancy until fetal viability.

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

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

Investigational Procedures (Investigational) are those: 1) that have progressed to limited use on humans, but which are not generally accepted as proven and effective procedures within the organized medical community; or 2) that do not have final approval from the appropriate governmental regulatory body; or 3) that are not supported by scientific evidence which permits conclusions concerning the effect of the service, Drug or device on health outcomes; or 4) that do not improve the health outcome of the patient treated; or 5) that are not as beneficial as any established alternative; or 6) whose results outside the Investigational setting cannot be demonstrated or duplicated; or 7) that are not generally approved or used by Physicians in the medical community. We have discretion to make this determination.

Maximum Allowed Amount for this plan is the maximum amount of reimbursement we will allow for Covered Services and supplies. See the section entitled "Maximum Allowed Amount" in the Part entitled "ANNUAL DEDUCTIBLES, MAXIMUM ALLOWED AMOUNT AND ANNUAL OUT-OF-POCKET MAXIMUMS**."**

Medical Emergency means a sudden onset of a medical condition or psychiatric condition manifesting itself by acute symptoms of sufficient severity including without limitation sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably result in:

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

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

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

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

Mental or Nervous Disorders and Substance Abuse are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental or Nervous Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental or Nervous Disorders are: schizophrenia; manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Severe Mental Illness, Serious Emotional Disturbances of a Child and any condition meeting these definitions is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Certificate. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with these mental conditions (for example, self-inflicted injuries) and treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child are not subject to this limitation, but shall be covered or not covered on the same terms as any other medical condition.**

Non-Participating Provider (Non-Participating) is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider agreement in effect with Anthem Blue Cross Life and Health Insurance Company for this plan at the time services are rendered:

- Ambulatory Surgical Center
- Clinical laboratory
- Durable medical equipment outlet
- Facility which provides diagnostic imaging services
- Home Health Agency or Visiting Nurse Association
- Home Infusion Therapy provider
- Hospice
- Hospital
- Licensed ambulance company
- Licensed Qualified Autism Service Provider
- Physician
- Retail Health Clinic
- Skilled Nursing Facility
- Urgent Care Center

Only a portion of the amount which a Non-Participating Provider charges for services will be paid by us. The Insured will be responsible for any charges billed by a Non-Participating Provider over the Maximum Allowed Amount specified in this Certificate. See the Part entitled "HOSPITAL AND LIMITED PROFESSIONAL BENEFITS - WHAT IS COVERED" to determine your payment responsibility when using Non-Participating Providers.

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

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

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

Participating Provider (Participating) is one of the following providers that has a Prudent Buyer Plan Participating Provider agreement in effect with us and has negotiated certain charges as the Maximum Allowed Amount they will charge our Insureds for Covered Services under this Certificate.

- Ambulatory Surgical Center
- Clinical laboratory
- Durable medical equipment outlet
- Facility which provides diagnostic imaging services
- Home Health Agency or Visiting Nurse Association
- Home Infusion Therapy provider
- Hospice
- Hospital

- Licensed ambulance company
- Licensed Qualified Autism Service Provider
- Physician
- Retail Health Clinic
- Skilled Nursing Facility
- Urgent Care Center

A directory of local Anthem Blue Cross Life and Health Insurance Company Participating Providers is available by calling our customer service department toll free number at (800) 627-8797, or through our web site **www.anthem.com**.

Physician means:

1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is (a) licensed to practice where the care is provided, (b) rendering a service within the scope of that license and such license is required to render the service, and (c) providing a service for which benefits are specified in this Certificate when those benefits would be payable if the services had been provided by a Physician as defined in paragraph 1. above:

    - Acupuncturist
    - Audiologist*
    - Certified nurse midwife
    - Certified registered nurse anesthetist
    - Chiropractor (D.C.)
    - Clinical psychologist
    - Dentist (D.D.S.)
    - Dispensing optician
    - Licensed clinical social worker (L.C.S.W.)
    - Licensed educational psychologist for the provision of behavioral health treatment of Pervasive Developmental Disorder or autism only.
    - Licensed professional clinical counselor (L.P.C.C.)
    - Marriage & Family Therapist (M.F.T.)
    - Occupational therapist (O.T.R.)*
    - Optometrist (O.D.)
    - Physical therapist (P.T. or R.P.T.)*
    - Podiatrist or chiropodist (D.P.M. or D.S.C.)
    - Psychiatric mental health nurse*
    - Registered nurse practitioner (R.N.P.)*
    - Respiratory therapist*
    - Speech pathologist*

    ***Note:** The providers indicated by an asterisk (*) are covered only by referral of a Physician as defined in 1. above.

Policy is the Group Insurance Policy issued by Anthem Blue Cross Life and Health Insurance Company to the Employer (Group) as a means of providing certain benefits to the employees and the eligible Dependents of the employees.

Policy Date is the date the Policy between Anthem Blue Cross Life and Health Insurance Company and the Employer comes into effect.

Policyholder is the Employer.

Retail Health Clinic is a facility that provides limited basic medical care services to Insureds on a "walk-in" basis. These clinics normally operate in major Pharmacies or retail stores. Medical services are typically provided by medical professionals who provide basic medical services.

Serious Emotional Disturbances of a Child is defined by the presence of one or more Mental Disorders as identified in the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the Child's age according to expected developmental norm. The Child must also meet one or more of the following criteria: 1) as a result of the Mental Disorder, the Child has substantial impairment in at least two of the following areas: a) self care, b) school functioning, c) family relationships, or d) ability to function in the community, and either the Child is at risk of being removed from the home or has already been removed from the home, or the Mental Disorder and impairments have been present for more than six (6) months or are likely to continue for more than one year without treatment; 2) the Child displays one of the following: a) psychotic features, b) risk of suicide, or c) risk of violence; 3) the Child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

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

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

Note: Coverage for Severe Mental Illness will be provided in accordance with the plan provisions for any other medical diagnosis and not in accordance with the plan provisions for Mental or Nervous Disorders.

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

Special Footwear is Medically Necessary Special Footwear, orthotic devices and services for foot disfigurement resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, injury or developmental disability. **Note:** Footwear for the treatment of weak, strained or flat feet, corns, calluses, bunions, hammertoes, fissures, plantar warts, cracks, ingrown toenails, or conditions caused by external sources, such as ill-fitting shoes or repeated friction, are not covered under this Certificate.

Spouse is the Certificateholder's Spouse under a legally valid marriage.

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

Totally Disabled means a person who is unable because of the disability to engage in any occupation to which he or she is suited by reason of training or experience, and is not in fact employed.

Urgent Care means those services necessary to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent Care services are not Medical Emergency services.

Urgent Care Center is a Physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a Hospital emergency department, usually on an unscheduled, walk-in basis. Urgent Care Centers are staffed by medical doctors, registered nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an Urgent Care Center, please call us at the customer service number listed on your ID card or you can also search online using the "Provider Finder" function on our website at **www.anthem.com**. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

Utilization Review means those functions performed by us to evaluate and approve whether the services provided, or to be provided, are Medically Necessary.

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

The following notice(s) are not part of the Certificate. They are important mandated notices required by either state or federal law.

- Notice of Language Assistance
- HIPAA Notice of Privacy Practices with Women's Health and Cancer Rights
- Member Rights and Responsibilities

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-800-627-8797. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-800-627-8797. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-800-627-8797 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-800-627-8797 .Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-800-627-8797. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-800-627-8797번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-800-627-8797 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-800-627-8797. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-800-627-8797までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。 Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-800-627-8797 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-800-627-8797 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-800-627-8797 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-800-627-8797. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-800-627-8797. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

Information that's important to you

Anthem Blue Cross
Health. Join In.℠

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com/ca and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.
If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

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Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Your Rights and Responsibilities as an Anthem Member

As an Anthem member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
    - Your health care plan
    - Any care you get
    - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your coverage booklet.