

Combined Evidence of Coverage and Disclosure Form

████████ Premier DirectAccess - ceab
0RYL

A Preferred Provider Organization (PPO) Plan



We've marked this EOC up for EDUCATION Use only!

If this EOC ever was advertising, it no longer is as we've redacted the name of the insurer. Insurance Code 787 c 2 i

Specimen

████████
P.O. Box 9051
Oxnard, CA 93031-9051

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SUMMARY OF BENEFITS

Anthem Premier DirectAccess - ceab
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A Preferred Provider Organization (PPO) Plan
A Platinum Plan

This SUMMARY OF BENEFITS sets forth the applicable Cost Shares for benefits available under this Agreement. The term Cost Shares means the applicable Deductibles, Out of Pocket Maximums, Coinsurance and Copayments that You must pay for Covered Services You receive under this Agreement. This SUMMARY OF BENEFITS does not list all specific services available under this Agreement, their Cost Shares, or explain benefits, exclusions or limitations. For a complete explanation of the benefits available under this Agreement and any limitations and exclusions, please read the entire Agreement including the parts WHAT IS COVERED – MEDICAL, WHAT IS COVERED – PRESCRIPTION DRUGS, WHAT IS NOT COVERED (Exclusions) – MEDICAL, WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS, CLAIMS AND PAYMENTS and GETTING APPROVAL FOR BENEFITS.

All benefits are subject to the conditions, exclusions, limitations and terms of this Agreement including any endorsements.

Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the part CLAIMS AND PAYMENTS for more details.

Benefits for Emergency or urgent care are based on the Reasonable and Customary Value, which is the most Anthem will allow for Emergency care. Please read the part WHAT IS COVERED - MEDICAL for more details. When You receive Emergency services (except ambulance services) from an Out of Network Provider within California, You will not be responsible for amounts in excess of the Reasonable and Customary Value. [learn more]

Deductibles and Coinsurance are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Customer Service 1-855-383-7247 or www.██████████

View our website
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Medical Deductible	In Network	Out of Network
Individual	\$0 per Benefit Period	\$5,000 per Benefit Period
Family	\$0 per Benefit Period	\$10,000 per Benefit Period
Prescription Drug Deductible		
Individual	\$0 per Benefit Period	Combined with Out of Network Medical Deductible
Family	\$0 per Benefit Period	Combined with Out of Network Medical Deductible
<p>Your benefits include no In Network Medical Deductible, no In Network Prescription Drug Deductible and a separate Out of Network Medical Deductible and Prescription Drug Deductible for Covered Services. For each Benefit Period, You must first satisfy the applicable Deductible. Unless stated otherwise, all amounts You pay for Out of Network Covered Services during a Benefit Period will apply towards Your Out of Network Medical Deductible or Your Out of Network Prescription Drug Deductible, as applicable. Your Out of Network Medical and Prescription Drug Deductible for Covered Services will apply towards Your Out of Network Out of Pocket Maximum.</p> <p>See "Deductibles" in CLAIMS AND PAYMENTS for a detailed description of how Your Deductible works.</p>		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Out of Pocket Maximum	In Network	Out of Network
Individual	\$4,000 per Benefit Period	\$10,000 per Benefit Period
Family	\$8,000 per Benefit Period	\$20,000 per Benefit Period

The Pocket Maximums include all Deductibles, Coinsurance, and Copayments You pay during a Benefit Period for all Essential Health Benefits, medical services, pediatric vision and Prescription Drug services combined. It does not include charges over the benefit limits, over the Maximum Allowed Amount, Precertification Copayments, or amounts You pay for non-Covered Services.

Once the applicable Out of Pocket Maximum is satisfied, You will not have to pay any additional Deductibles, Copayments or Coinsurance for the rest of the Benefit Period.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period for the Medical Deductible, Prescription Drug Deductible, Coinsurance and Copayments apply to the Out of Pocket Maximum.

Charges over the Maximum Allowed Amount that are Your responsibility, amounts You pay for non-Covered Services and Copayments for not obtaining required Precertification do not apply to these Out of Pocket Maximums. Deductibles and Coinsurance are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

The In Network and Out of Network Out of Pocket Maximums are separate and do not apply toward each other.

See "Out of Pocket Maximum" in CLAIMS AND PAYMENTS for a detailed description of how Your Out of Pocket Maximum works.

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

COINSURANCE AND COPAYMENTS

The following lists the Coinsurance and Copayment for benefits under this Agreement. The following does not list all services or the locations where a service may be received. If a service is available in another setting You may determine the applicable Cost Share by referring to that setting. For example, You might get Physical Therapy in a Physician's office, an outpatient Hospital Facility, or during an inpatient Hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a Hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Cost Sharing for services with Copayments is the lesser of the Copayment amount or Maximum Allowed Amount.

Benefits for Covered Services are based on the **Maximum Allowed Amount**, which is the most Anthem will allow for a Covered Service **not the Provider's billed charges**. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles and non-covered charges. This amount can be substantial. Please read the part CLAIMS AND PAYMENTS for more details.

Some services listed below require **Precertification** prior to receiving the service. See the part GETTING APPROVAL FOR BENEFITS for more information. If You do not obtain Precertification, You may be subject to an additional Copayment of \$250. The Precertification Copayment does not apply towards Your Deductible or Your Out of Pocket Maximum.


Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

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Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Ambulance Services (Ground, Air and Water) Precertification is required for ambulance services except in a Medical Emergency	\$150 Copayment	Emergency: \$150 Copayment plus all charges in excess of the Reasonable and Customary Value Non Emergency: 40% Coinsurance plus all charges in excess of the Reasonable and Customary Value
[web md]		
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism		
Acute care Facility Precertification is required for acute care Facility services	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient services	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Emergency Care (Emergency Room)	\$150 Copayment Copayment is waived if admitted into the Hospital from the Emergency room	\$150 Copayment Copayment is waived if admitted into the Hospital from the Emergency room

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Habilitation Services  [learn more]	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Home Care Services <ul style="list-style-type: none"> • Precertification is required for home care services • Out of Network home care services are limited to 100 visits per Benefit Period 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Hospice Care	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Inpatient Facility Services <ul style="list-style-type: none"> • Precertification is required for inpatient Facility services • Out of Network inpatient Facility Copayment is not subject to the Out of Network Deductible • Out of Network Inpatient Facility requires Copayment per admission in a non Emergency 		Non Emergency: \$1,000 Copayment
For non Emergency Out of Network Providers, the Coinsurance below is in addition to the Out of Network inpatient Facility Services Copayment		
Inpatient Facility care (Hospital)	10% Coinsurance	Emergency: 10% Coinsurance Non Emergency: 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Residential Treatment Center Facility	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Services received in the inpatient Facility	10% Coinsurance	Emergency: 10% Coinsurance Non Emergency: 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physicians that bill separately from Facility charges	10% Coinsurance	Emergency: 10% Coinsurance Non Emergency: 40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Maternity Care		
Preconception and prenatal care	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Postnatal care	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Delivery and inpatient Facility services	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Mental Health and Substance Abuse (Chemical Dependency) Services		
Mental Health and Substance Abuse acute care Facility Precertification is required for Mental Health and Substance Abuse Facility services	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Outpatient services	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Office Visits		
<ul style="list-style-type: none"> • Additional services received during an Office Visit may be subject to additional Coinsurance or Copayments • For Preventive Care visits, please see Preventive Care below 		
Primary Care Physician and Primary Care Provider (PCP)	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Specialty Care Physician and Specialty Care Provider (SCP)	\$40 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Retail health clinic visit	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Online care visit	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Telehealth	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
<p>Office Visits – Additional Services in an Office, Outpatient or Urgent Care</p> <p>In addition to the applicable Office Visit (PCP or SCP), outpatient surgery services or urgent care Copayments, if You receive other services as indicated below, the Cost Share for those services will also apply</p>		
Diagnostic laboratory and pathology services	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Diagnostic imaging services and electronic diagnostic tests	\$40 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Advanced diagnostic imaging services	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other Eligible Providers If You obtain services from Other Eligible Providers, Your responsibility will be 10% Coinsurance plus all charges in excess of the Maximum Allowed Amount		
Outpatient Surgery Services Additional services received in an outpatient surgery Facility may be subject to additional Coinsurance or Copayments		
Facility charge	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Services received in the outpatient Facility	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physician / Surgeon charges (including but not limited to surgeon, anesthesiologist, pathologist, and radiologist)	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preventive Care	0% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Rehabilitation Services		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Acupuncture	\$40 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physical Therapy / Occupational Therapy / Speech Therapy Precertification is required for Physical, Occupational and Speech Therapy	\$20 Copayment	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Skilled Nursing Facility <ul style="list-style-type: none"> • Precertification is required for a Skilled Nursing Facility • Out of Network Skilled Nursing Facility is limited to 100 days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A Skilled Nursing Day Allowance ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends. A prior three-day stay in an acute care hospital is not required to commence a Skilled Nursing Day Allowance. 	10% Coinsurance	40% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Urgent Care Additional services received in an urgent care may be subject to additional Coinsurance or Copayments	\$40 Copayment	Emergency: \$40 Copayment Non Emergency: 40% Coinsurance plus all charges in excess of the Reasonable and Customary Value
Vision – Pediatric Vision Services Members through age 18		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Routine Eye Exam Once every Benefit Period	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Comprehensive Low Vision Exam Once every five (5) Benefit Periods	\$0 Copayment	Not covered
Optical/Non-Optical Aids and Supplemental Testing Limited to one (1) occurrence of either optical/non-optical aids or supplemental testing per Benefit Period	\$0 Copayment	Not covered
Standard Plastic or Glass Lenses* <ul style="list-style-type: none"> • Once every Benefit Period • Include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. 		
Single Vision	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Bifocal	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Trifocal	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Progressive	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Frames* (formulary) <ul style="list-style-type: none"> Once every Benefit Period This Agreement offers a selection of covered frames 	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Contact Lenses (formulary)* <ul style="list-style-type: none"> A one (1) Year supply is covered every Benefit Period (applicable to certain contact lenses within the formulary) Contact lenses for Aniridia will be covered up to two (2) contact lenses per eye (including fitting and dispensing) per Benefit Period Contact lenses for Aphakia will be covered up to six (6) contact lenses per eye (including fitting and dispensing) per Benefit Period This Agreement offers a selection of covered contact lenses Fitting and evaluation of contact lenses is not a covered benefit and will be an additional cost to the Member 		
Elective (conventional and disposable) These are contact lenses chosen for comfort or appearance	\$0 Copayment	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
Non-elective These are contact lenses that are prescribed to You for a medical condition	Covered in full	\$0 Copayment plus all charges in excess of the Maximum Allowed Amount
*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in this SUMMARY OF BENEFITS.		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

<p>PRESCRIPTION DRUG BENEFITS</p> <p>Prescription Drug benefits accumulate toward the applicable Out of Pocket Maximum You must pay the applicable Deductible before Your benefits begin</p>
<p>Each Prescription Drug will be subject to a Copayment/Coinsurance as described below. If Your Prescription Drug order includes more than one Prescription Drug, a separate Copayment/Coinsurance will apply to each Prescription Drug.</p>
<p>IMPORTANT NOTE: Benefits for Covered Services are based on the Prescription Drug Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Prescription Drug Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the parts CLAIMS AND PAYMENTS and WHAT IS COVERED – PRESCRIPTION DRUGS for more details.</p>
<p>See the parts WHAT IS COVERED – PRESCRIPTION DRUGS and WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for descriptions of Covered Services, limitations and exclusions.</p>

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Prescription Drug Deductible (retail & home delivery combined)		
Individual	\$0	Out of Network Prescription Drugs are subject to the same Deductible as Your Medical Benefits
Family	\$0	Out of Network Prescription Drugs are subject to the same Deductible as Your Medical Benefits
Retail Prescription – 30 day supply		

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

Benefit	You Pay	
	Coinsurance / Copayment	
	In Network	Out of Network
Tier 1	\$5.00 Copayment	40% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 2	\$15.00 Copayment	40% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 3	\$25.00 Copayment	40% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 4	10% Coinsurance	40% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Specialty Drugs – 30 day supply PLEASE NOTE: Specialty Drugs are covered only when purchased from the Specialty Preferred Provider. Please read the part WHAT IS COVERED – PRESCRIPTION DRUGS under Specialty Pharmacy for more information on Specialty Drugs.	10% Coinsurance	Not covered
Home Delivery Prescription – 90 day supply		
Tier 1	\$10.00 Copayment	Not covered
Tier 2	\$37.50 Copayment	Not covered

Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

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Benefit	You Pay Coinsurance / Copayment	
	In Network	Out of Network
Tier 3	\$62.50 Copayment	Not covered

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Such benefits shall be consistent with those set forth under Federal and California laws and regulations and any regulations issued pursuant thereto.

SUMMARY OF BENEFITS

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Anthem Premier DirectAccess - ceab

INTRODUCTION

This **Evidence of Coverage** (also called the Agreement), explains many of the rights and duties between You and us. It also describes how to get health care, what services are covered, and what part of the costs You will need to pay. Many parts of this Agreement are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage. **You should read the whole Agreement** to know the terms of Your coverage. Please read the Agreement completely and carefully. Individuals with special health care needs should carefully read those sections that apply to them.

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

ONCE ENROLLED, YOU HAVE **THIRTY (30) DAYS** FROM THE DATE OF DELIVERY TO EXAMINE THIS AGREEMENT. IF YOU ARE NOT SATISFIED, **FOR ANY REASON** WITH THE TERMS OF THIS AGREEMENT, YOU MAY RETURN THE AGREEMENT TO US WITHIN THOSE THIRTY (30) DAYS. YOU, CONSISTENT WITH CALIFORNIA LAW, WILL BE REQUIRED TO PAY FOR ANY SERVICES **[REDACTED]** PAID ON YOUR BEHALF DURING THE THIRTY (30) DAY PERIOD AND ANTHEM BLUE CROSS WILL REFUND ANY PREMIUM PAID BY YOU, LESS YOUR MEDICAL AND PHARMACY EXPENSES THAT ANTHEM BLUE CROSS PAID. IF NO SERVICES WERE RENDERED, YOU WILL BE ENTITLED TO RECEIVE A FULL REFUND OF ANY PREMIUMS PAID. THIS AGREEMENT WILL THEN BE NULL AND VOID.

THE ENTIRE AGREEMENT SETS FORTH, IN DETAIL THE RIGHTS AND OBLIGATIONS OF BOTH YOU AND **[REDACTED]**. IT IS, THEREFORE, IMPORTANT THAT YOU READ THE ENTIRE AGREEMENT CAREFULLY. PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS SHOULD READ THOSE SECTIONS THAT APPLY TO THEM.

[REDACTED] enters into this Agreement with You based upon the answers submitted by You and Your applicable Dependents on the **signed individual enrollment application**. In consideration for the payment of the Premiums stated in this Agreement, we will provide the services and benefits listed in this Agreement to You and Your enrolled Dependents.

Customer Service 1-855-383-7247 or www.██████████

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

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

Specimen

IN THIS AGREEMENT, "WE," "US", "OUR", AND "A [REDACTED]" SHALL MEAN [REDACTED]. YOU ARE THE ELIGIBLE SUBSCRIBER WHOSE INDIVIDUAL ENROLLMENT APPLICATION HAS BEEN ACCEPTED BY US. "YOU" AND "YOUR" ALSO MEAN ANY ELIGIBLE DEPENDENTS WHO ARE COVERED UNDER THIS AGREEMENT. WHEN WE USE THE WORD "MEMBER" IN THIS AGREEMENT, WE MEAN YOU AND ANY ELIGIBLE DEPENDENTS WHO ARE COVERED UNDER THIS AGREEMENT.

Newborns are covered during the first thirty-one (31) days from birth and Adopted Children are covered during the first thirty-one (31) days from the date the Subscriber, enrolled spouse, or enrolled Domestic Partner is granted the right to control health care for an Adopted Child. Refer to the part YOUR ELIGIBILITY for additional information about coverage of Newborns and Adopted Children.

CHOICE OF IN NETWORK FACILITY, IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER

You have the right to choose an In Network Facility, In Network Provider, or Out of Network Provider. Choosing an Out of Network Provider may impact Your personal financial costs. Refer to the SUMMARY OF BENEFITS to review Copayment and Coinsurance differences between these types of Providers since Your responsibility is often significantly higher when You use an Out of Network Provider.

How to Find a Provider in the Network

There are three ways You can find out if a Provider or Facility is in the network for this Agreement. You can also find out where they are located and details about their license or training.

- See our directory of In Network Providers at www.anthem.com/ca, which lists the Physicians, Providers and Facilities that participate in our network.
- Call customer service at [REDACTED] or access our website at [REDACTED] for a list of Physicians, Providers and Facilities that participate in our network, based on specialty and geographic area.
- Check with Your Physician or Provider.

If You need help choosing a Physician who is right for You, call the customer service number at [REDACTED], the number on the back of Your Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

Note: We have several Provider networks, and that a Provider that is In Network for one Agreement may not be In Network for another. Be sure to call customer service to find out which network this Agreement uses.

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under Your Agreement 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 Subscriber or select a network Provider. Call Your perspective doctor or clinic, or call [REDACTED] to ensure that You can obtain the health care services that You need.

Providers are independent contractors. [REDACTED] is not responsible for any claim for damages or injuries suffered by the Member while receiving care from any Provider.

You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling our customer service department at 1-[REDACTED] or by accessing our website at www.[REDACTED]

How to Get Language Assistance

Anthem offers a Language Assistance Program to assist Members with limited English proficiency understand the health coverage of this Agreement at no additional cost. We provide oral interpretation services. We will also provide written translation for certain written materials vital to understanding Your health coverage.

Requesting language assistance is easy. Just contact Customer Service by calling the phone number on Your Identification Card, 1-[REDACTED], to update Your language preference to receive future translated documents or to request interpretation assistance. Anthem also sends/receives TDD/TTY messages at 1-866-333-4823 or by using the National Relay Service through 711. A special operator will get in touch with us to help with Your needs. For more information about the Language Assistance Program visit [www.\[REDACTED\]](http://www.[REDACTED])

Written materials available for translation include Grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Triage or Screening Services.

If You have questions about a particular health condition or if You need someone to help You determine whether or not care is needed, triage or screening services are available to You from us by telephone. Triage or screening services are the evaluation of Your health by a Physician or a nurse who is trained to screen for the purpose of determining the urgency of Your need for care. Please contact the 24/7 NurseLine at 1-866-623-3790 24 hours a day, 7 days a week.

THIS IS NOT AN ANNUAL AGREEMENT. The Plan period is **monthly** and defines the period of Your coverage but does not affect and is not affected by any provisions defining **Your Deductible** or other cost-sharing obligations which

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are calculated on a Yearly basis. Your Agreement expires at the end of each monthly Plan Period but will automatically renew upon timely payment by the Monthly Premium Due Date of the Premium for the next monthly Plan Period, unless we have exercised our right to terminate, cancel or non-renew as described in this Agreement. Premiums, benefits, terms, Deductibles, Out of Pocket Maximums and conditions may be modified effective at any renewal date following sixty (60) days written notice to You, and such changes may be implemented at any time during the next Plan Period following renewal. Please read this Agreement, and in particular, all the sections under the parts RIGHT TO MODIFY OR CHANGE THE AGREEMENT and YOUR ELIGIBILITY carefully and in its entirety to make sure You fully understand the duration of Your coverage and the conditions under which we can change, terminate, cancel or decline to renew Your Agreement.

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Customer Service 1 [REDACTED]

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RIGHT TO MODIFY OR CHANGE THE AGREEMENT

[REDACTED] has the right to modify or otherwise change the terms, benefits, and conditions of the Agreement, including without limitation, Premiums, covered benefits, Deductibles, Copayments or Coinsurance, as set forth herein.

[REDACTED] must provide sixty (60) days written notice of any such modifications or changes. The modifications shall be made at renewal of the Plan Period, and may be implemented on the Monthly Premiums Due Date or during the Plan Period following completion of the sixty (60) day notice period. The right to modify Your Agreement on sixty (60) day notice is not affected by the use of calendar Year or annual time periods to measure or determine Deductibles or maximum Copayments or Coinsurance.

[REDACTED] will not modify this Agreement on an individual basis, but only for all Members covered under the same Agreement as You.

Specimen

RIGHT TO MODIFY OR CHANGE THE AGREEMENT

YOUR ELIGIBILITY

This part explains open enrollment, when coverage begins, who is eligible for coverage, monthly Premiums, and events that may cause eligibility to change, for example, birth, adoption, marriage, divorce, Domestic Partnership or dissolution of Domestic Partnership.

Who is Eligible for Coverage

Subscriber

To be eligible for membership as a Subscriber under this Agreement, the applicant must:

1. Be a United States citizen or national; or
2. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3. Be a legal resident of California;
4. Reside in the Service Area;
5. Agree to pay for the cost of Premium that Anthem requires;
6. Not be incarcerated (except pending disposition of charges);
7. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D;
8. Not be covered by any other group or individual health benefit plan.

Dependents

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form required by Anthem and meet all Dependent eligibility criteria:

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner, provided the Subscriber and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, and the Domestic Partnership has not terminated. The Domestic Partner does not include any person who is covered as a Subscriber or spouse. For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse and a Domestic Partner's child, Adopted Child or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.
3. The Subscriber's or the Subscriber's spouse's or Domestic Partner's children, including stepchildren, Newborn and Adopted Children and any child for whom the Policyholder has assumed a parent-child relationship under age twenty six (26).

YOUR ELIGIBILITY

4. Children **under age twenty-six (26)** for whom the Subscriber or the Subscriber's spouse or Subscriber's Domestic Partner is a legal guardian.

Eligibility will be continued past the age limit of twenty-six (26) as an Overage Dependent **only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability.** To qualify as an Overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Anthem shall determine whether the Dependent meets those criteria before the Dependent attains the limiting age.

1. Ninety (90) days before the Dependent reaches the age limit of twenty-six (26), Anthem will issue a request for proof that the Dependent continues to meet the criteria for continued coverage.
2. The Subscriber must submit written proof of such dependency within sixty (60) days of receiving the request.
3. Before the date the Dependent reaches the age limit of twenty-six (26), Anthem will determine whether the Dependent meets the criteria for continued coverage.
4. Two (2) years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.
5. Anthem may request a new Subscriber to provide information regarding a Dependent with a continued physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the Dependent meets the criteria for continued coverage. The Subscriber must submit written proof of such dependency within sixty (60) days of receiving the request.

We may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Newborn and Adopted Child Coverage

Newborn and adopted child(ren) of the Subscriber or the Subscriber's spouse will be covered for an initial period of sixty (60) days from the date of birth or adoption. Coverage for Newborn and adopted child(ren) will continue beyond the sixty (60) days, provided the Subscriber submits through us a form to add the child under the Subscriber's Agreement. The form must be submitted along with the additional Premium, if applicable, within sixty (60) days after the birth of the child. Failure to notify us and pay any applicable Premium during this sixty (60) day period will result in no coverage for the Newborn or Adopted Child beyond the first sixty (60) days.

YOUR ELIGIBILITY

A child will be considered adopted from the earlier of:

1. the moment of placement for adoption; or
2. the date of an entry of an order granting custody of the child to You.

The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

NEWBORN AND ADOPTED CHILDREN OF THE SUBSCRIBER'S, SUBSCRIBER'S SPOUSE'S OR SUBSCRIBER'S DOMESTIC PARTNER'S DEPENDENT CHILDREN ARE NOT COVERED UNDER THIS AGREEMENT.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Agreement must be submitted to us within sixty (60) days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Reminder: Newborn or Adopted Child(ren) covered under this Agreement may cause the applicable Deductible and/or Copayment or Coinsurance maximums to automatically change from an Individual Agreement to a Family Agreement.

Individuals not eligible for Dependent coverage

- Spouses of Dependent children are not eligible for coverage under this Agreement.
- Children, including Newborns and Adopted Children, of Dependent children are not eligible for coverage under this Agreement unless that child meets other coverage criteria established under State law.
- Temporary custody is not sufficient to establish eligibility under this Agreement.
- Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Agreement unless required by the laws of this State.

YOUR ELIGIBILITY

Qualified Medical Child Support Order

If You are required by a Qualified Medical Child Support Order or court order, as defined by applicable State or federal law, to enroll Your child under this Agreement, and the child is otherwise eligible for the coverage, we will permit Your child to enroll under this Agreement, and we will provide the benefits of this Agreement in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the SUMMARY OF BENEFITS and above in "Who Is Eligible for Coverage – Dependents". Any claims covered under this Agreement will be allowed to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Open Enrollment

An annual open enrollment period is provided for enrollees in compliance with state and federal requirements. Individuals may enroll in an Agreement and Members may change their Agreement at that time.

Effective Dates for annual open enrollment period:

The earliest Effective Date is the first day of the following Benefit Period. The actual Effective Date is determined by the date ██████ receives a complete application with the applicable Premium Payment.

If Payment is received between the 1st through 15th of the month, the effective date is the first of the next month. If Payment is received between the 16th through end of the month, the effective date is the first of the month after the next month.

Special Enrollment

A special enrollment period is a period during which the Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in an Agreement, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, the Member or enrollee has sixty (60) calendar days from the date of a qualifying event to select an Agreement.

YOUR ELIGIBILITY

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage (loss of Minimum Essential Coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility **does not** include a loss due to the failure of the employee or Dependent to **pay Premiums** on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an **intentional misrepresentation of a material** fact in connection with the plan)
- Gain a Dependent or become a Dependent through marriage, Domestic Partnership, birth, adoption, placement for adoption or appointment of Domestic Partnership
- Mandated to be covered as a Dependent pursuant to a valid state or federal court order
- Release from incarceration
- Health coverage issuer substantially violated material provision of health coverage contract
- Access to new health benefit plans due to permanent move
- Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of Newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the Provider) and that Provider is no longer participating in the health benefit plan
- Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, Domestic partnership or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after Your application is received.

You must elect coverage and notify us within sixty (60) days.

YOUR ELIGIBILITY

Effective Dates for special enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation, dissolution of Domestic partnership or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
 - a. Individual who no longer resides, lives or works in the Agreement's Service Area,
 - b. A situation in which the Agreement no longer offers any benefits to the class of similarly situated individuals that includes the individual,
 - c. Termination of employer contributions, and
 - d. Exhaustion of COBRA benefits.

There is no special enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Agreement. We must be notified of any changes as soon as possible but no later than within sixty (60) days of the event. This includes changes in address, marriage, divorce, dissolution of Domestic Partnership, death, change of Dependent disability or dependency status. Failure to notify us of persons no longer eligible for services will not obligate us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate us to pay for such services.

A Family Agreement will be changed to an Individual Agreement when only the Subscriber remains eligible. When notice is provided within sixty (60) days of the event, the Effective Date of coverage is the date of the event causing the change to an Individual Agreement. Anthem must be notified when the Member becomes eligible for Medicare.

YOUR ELIGIBILITY

Customer Service [REDACTED] 383-7247 or www.[REDACTED]

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All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Contact customer service at 1-855-383-7247 or send Your request to us at:

[REDACTED]
P.O. Box 9051
Oxnard, California 93031-9051

Statements and Forms

Subscribers or applicants (including applicants to be covered as a Dependent) for coverage shall complete and submit to Anthem any applications or other forms or statements that we may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to Anthem are true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Agreement are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

Plan Period

This is a monthly Agreement. This Agreement shall automatically renew upon timely Premium Payment of the entire Premium amount billed by the Monthly Premium Due Date.

THIS IS NOT AN ANNUAL AGREEMENT. The Plan period is monthly and defines the period of Your coverage but does not affect and is not affected by any provisions defining Your Deductible or other cost-sharing obligations which are **calculated on a Yearly basis**. Your Agreement expires at the end of each monthly Plan Period but will automatically renew upon timely payment by the Monthly Premium Due Date of the Premium for the next monthly Plan Period, unless we have exercised our right to terminate, cancel or non-renew as described in this Agreement. Premiums, benefits, terms, Deductibles, Out of Pocket Maximums and conditions may be modified effective at any renewal date following sixty (60) days written notice to You, and such changes may be implemented at any time during the next Plan Period following renewal. Please read this Agreement, and in particular, all the sections under

YOUR ELIGIBILITY

the parts RIGHT TO MODIFY OR CHANGE THE AGREEMENT and YOUR ELIGIBILITY carefully and in its entirety to make sure You fully understand the duration of Your coverage and the conditions under which we can change, terminate, cancel or decline to renew Your Agreement.

Monthly Premiums

Premiums are the monthly charges You must pay Anthem to establish and maintain coverage. We determine and establish the required Premiums based on the Subscriber's age, number of Members, and the specific regional area in which the Subscriber resides. For children-only contracts, Premiums will be based upon the age of the youngest child. The youngest child will be considered the Subscriber.

When You initiate changes to the Agreement that result in a change to the Premiums, the changes to the Premiums will be reflected on the next billing statement. When Anthem initiates a change to this Agreement, we will provide You sixty (60) days advance written notification of the changes.

Monthly Premiums are printed in the appendix, Subscriber and Premium Information of this Agreement and on Your monthly billing statement. All Monthly Premium Payments and administrative fees are payable in advance and due on the Monthly Premium Due Date. The Monthly Premium Due Date is the first day of the Plan period for which we receive Premium Payment. For example, if the Plan Period is March 1 to March 31, the Monthly Premium Due Date is March 1. The Plan Period is not affected by and does not affect the use of other periods of time to measure or determine Your rights and benefits, for example, the use of the calendar Year as applied to Deductible, or the use of the calendar Year to determine maximum Copayments/Coinsurance.

If the Subscriber changes residence, he or she may be subject to a change in Premiums. Such change in Premiums will be effective on the next billing statement following notification of the change of residence. We will recalculate the Premiums to the new rate of Your regional area of residence. If the Subscriber does not notify us of a change in residence and we later learn of the change in residential address, we may bill the Subscriber for the difference in Premiums from the date the address changed.

How to pay Your Premium

You can make Your Premium Payment online [REDACTED] by contacting customer service at

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██████████ or **by mailing it to us.** For Your convenience, You may authorize us to **automatically deduct** Your Premium Payment from Your financial institution account every month. To learn more about this option, contact customer service.

If You choose to mail Your Premium Payment, send it to us at:

██████████

P.O. Box 54010

Los Angeles, California 90054

Electronic Funds Transfer

If You submit a personal check for Premiums Payment, You automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize us to deduct Premiums from Your account on a monthly basis unless You have given us prior authorization to do so.

Administrative Fee

An administrative fee of \$25 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

Guaranteed Renewable

Coverage under this Agreement is guaranteed renewable except as permitted to be cancelled, rescinded, or not renewed under applicable State and federal law. The Member may renew this Agreement by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Agreement, subject to the incontestability provision;
3. Membership has not been terminated by ██████████ under the terms of this Agreement; and
4. Membership has not been rescinded by ██████████

Termination

YOUR ELIGIBILITY

This section describes how coverage for Members can be canceled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to [REDACTED]
2. The Member no longer meets eligibility requirements for coverage under this Agreement.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Date of Termination

Except as otherwise provided, Your coverage may terminate in the following situations. This information provided below is general, and the actual Effective Date of termination may vary based on Your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If You terminate Your coverage, termination will be effective on the last day of the billing period in which we received Your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by us that the person no longer meets the definition of Dependent.
- If You permit the use of Your or any other Member's Agreement Identification Card by any other person, use another person's card, or use an invalid card to obtain services, Your coverage will terminate immediately upon our written notice. Any or Dependent involved in the misuse of an Identification Card will be liable to and must reimburse us based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services received through such misuse.
- If You engage in fraudulent conduct or furnish us fraudulent or misleading material information relating to claims, then we may terminate Your coverage. Termination is effective thirty-one (31) days after our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage was terminated.
- If You stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

YOUR ELIGIBILITY

IMPORTANT: Termination of the Agreement automatically terminates all Your coverage as of the date of Termination, whether or not a specific condition was incurred prior to the Termination date. Covered Services are eligible for payment only if Your Agreement is in effect at the time such services are provided.

Loss of Eligibility

Coverage ends for the Member when You or Your Dependents no longer meet the eligibility requirements for coverage under this Plan. You must timely furnish any information requested regarding Your eligibility and the eligibility of Your Dependents, including but not limited to, marriage, divorce, dissolution of Domestic Partnership, death, change of Dependent disability or dependent status. Failure to give timely notification of a loss of eligibility will not obligate us to provide benefits for ineligible persons, even if we have accepted Premiums or paid benefits.

Discontinuation of Health Coverage

Coverage under this Agreement will end if Anthem withdraws this individual health benefit plan from the individual health care market. We will give You ninety (90) days written notice before any such withdrawal. In addition, You will be given the option to purchase any individual health benefit plan that we make available to new individual businesses for an individual who may become eligible for the coverage. Nonrenewal of the Agreement will not affect a claim incurred before the nonrenewal.

Pediatric Dental Coverage

Except as described in the part WHAT IS COVERED – MEDICAL in the section "Dental Services" in the "What's Covered," dental services are not covered under this Agreement. Information in this Agreement, such as how to get care, descriptions of services that are covered, and how to resolve issues related to Your health care coverage, pertains only to Covered Services offered under this Agreement.

When You or any Dependent enroll in this Agreement's coverage, You and Your Dependents are also automatically enrolling in a separate pediatric dental plan, which will provide coverage of pediatric dental benefits for any children through the age of 19 that are enrolled. You and Your Dependents will be automatically enrolled in the ██████████ Pediatric Dental Plan[unless you select the ██████████ Enhanced Pediatric Dental Plan]. These dental benefits are described in the applicable pediatric dental evidence of coverage ("EOC").

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Please refer to the applicable pediatric dental EOC for information about Your dental coverage, such as how to get care, and services that are covered. Complaints, grievances and appeals that concern dental services covered by the applicable pediatric dental EOC will be addressed as set forth in the applicable pediatric dental EOC. Please refer to the applicable pediatric dental EOC regarding these complaints, grievances and appeals. Questions, complaints, grievances and appeals regarding enrollment, premium collection and/or termination relating to this pediatric dental coverage will be addressed as set forth in this EOC. Use the applicable pediatric dental EOC and this Plan's EOC as companion documents.

Renewal

Coverage of the pediatric dental benefits under the pediatric dental plan will automatically renew upon the renewal of this Agreement.

Premiums

Premiums due under this Agreement do not include the premiums for the pediatric dental plan. The premiums for the pediatric dental plan will be billed separately.

Termination

The pediatric dental plan will automatically terminate upon the termination of this Agreement. The pediatric dental plan will not and cannot terminate without terminating this Agreement.

Rescission of Agreement

IF WITHIN TWO (2) YEARS AFTER THE EFFECTIVE DATE OF THIS AGREEMENT, WE DISCOVER ANY ACT, PRACTICE OR OMISSION THAT CONSTITUTES FRAUD OR AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS THAT YOU OR YOUR DEPENDENTS KNEW, BUT DID NOT DISCLOSE ON YOUR APPLICATION, WE MAY RESCIND THIS AGREEMENT AS OF THE ORIGINAL EFFECTIVE DATE. ADDITIONALLY, IF WITHIN TWO (2) YEARS AFTER ADDING ADDITIONAL DEPENDENTS (EXCLUDING ELIGIBLE NEWBORN CHILDREN ADDED WITHIN SIXTY (60) DAYS AFTER BIRTH), WE DISCOVER ANY ACT, PRACTICE OR OMISSION THAT CONSTITUTES FRAUD OR AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACTS THAT YOU OR YOUR DEPENDENTS KNEW, BUT DID NOT DISCLOSE IN YOUR APPLICATION, WE MAY RESCIND COVERAGE FOR THE ADDITIONAL DEPENDENT AS OF THE DATE HE OR SHE ORIGINALLY BECAME EFFECTIVE.

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By signing the application, every Member age eighteen (18) or older acknowledged they had provided **true and complete** answers to all questions in the application to the best of their knowledge and understood that all answers were important and would be considered in the acceptance or denial of the application. Every Member age eighteen (18) or older further acknowledged that all information responsive to a question on the application was required to be provided in their answers consistent with California law. If [REDACTED] discovers that You committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in the application, [REDACTED] may rescind this Agreement within the first twenty-four (24) months from Your Effective Date. This means that Anthem will revoke Your Agreement as if it never existed back to the original Effective Date.

By signing the application, You additionally acknowledged that all of Your Dependents listed on the application who were eighteen (18) years of age or older read the application and provided true and complete information on the application to the best of Your knowledge. You further acknowledged that to the best of Your knowledge and belief, that You had done everything necessary to be able to assure Anthem that all information about all applicants, including Your children under the age of eighteen (18) listed on the application, was true and complete. Anthem may rescind the entire Agreement, within the first twenty-four (24) months from Your Effective Date if it discovers that You committed an act, practice or omission that constitutes fraud or intentional misrepresentation of material fact is found in the application. Members other than the individual whose information led to the rescission may be able to obtain coverage as set forth below in Eligibility following Rescission.

This Agreement may also be terminated if You knowingly **participate in or permit fraud or deception** by any Provider, vendor or any other person associated with this Agreement. Termination for any act, practice or omission that constitutes fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give You at least thirty (30) days written notice prior to rescission of this Agreement. After the two (2) Years following Your Effective Date, we may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

If rescinded, You will have the option to submit a new application in the future to be considered for benefits. You, consistent with California law, will be required to pay for any services Anthem paid on Your behalf and Anthem will refund any Premium paid by You, less Your medical and Pharmacy expenses that [REDACTED] paid.

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If Your Agreement is rescinded, You will be sent thirty (30) days written notice that will explain the basis for the decision and Your appeal rights including the right to request review by us or the Department of Managed Health Care if You believe that this Agreement has or will be improperly rescinded.

Eligibility following Rescission

For a Plan that has been rescinded, eligible Members on such Plan may continue coverage in one of the following ways:

- enroll in a new Plan that provides same benefits, or
- remain covered under the Plan that was rescinded.

In either instance, Premiums may be revised to reflect the number of persons on the Plan.

We will notify in writing all Members of the right to coverage under a Plan, at a minimum, when we rescind the Plan.

We will provide sixty (60) days for Members to accept the offered new Plan and the contract shall be effective as of the Effective Date of the original Plan and there shall be no lapse in coverage.

YOUR ELIGIBILITY

Cancellation

Once this Agreement is canceled, the Member cannot reapply until the next annual open enrollment unless there is an event that qualifies for a special enrollment prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Agreement. If this happens, no benefits will be provided after the Member's termination date.

Reinstatement of Coverage for Members of the Military

Members who are members of the United States Military Reserve and National Guard who terminate their coverage of this Plan as a result of being ordered to active duty on or after January 1, 2007, may have their coverage reinstated. Please contact customer service at 1-855-383-7247 for information on how to apply for reinstatement of coverage following active duty as a reservist.

Grace Period

The grace period for payment of future premiums is thirty (30) days from the Monthly Premium Due Date. If You fail to pay premiums as they become due, ██████ may terminate this Agreement as described below as of the last day of the grace period.

██████ will terminate this Agreement only upon first giving You a written Notice of Grace Period after the Monthly Premium Due Date and at least thirty (30) days prior to that termination. The Notice of Grace Period shall state that this Agreement shall not be terminated if You make appropriate Payment in full within thirty (30) days after ██████ issues the Notice of Grace Period. You are not entitled to a grace period until You have made Your first payment to us. If You need covered benefits during the grace period, coverage will be provided. However, we will deduct the premiums due for coverage continued during the grace period from any benefits we pay.

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The Notice of Grace Period also shall inform You that, if this Agreement is terminated for non-payment of premiums, You may apply for reinstatement by submitting a new application and any premiums that are owed, and You will be subject to medical underwriting review to determine Your eligibility.

We will not provide benefits for any services received on or after the date Your coverage ends. Any claims paid for services received after coverage ends will be retroactively denied and You will be responsible for the billed charges, unless not allowed by law. If we are required to pay for claims received after the date that coverage ends, You will be responsible for a pro-rated premium through the last day that services were received. We may pursue collection action against You if you do not pay the pro-rated premium to us.

If this Agreement lapses (cancels) because You do not make Your Premium payment by the end of the grace period but Anthem then accepts a late Premium payment from You we will, at our discretion reinstate this Agreement.

Services Received After Coverage Ends

We will not cover services You receive after Your coverage ends with us. This is also stated in the part WHAT IS NOT COVERED (Exclusions) – MEDICAL and WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Refunds

If this Agreement is canceled or terminated for any reason, any Premium we receive for periods after the Effective Date of that termination, less any amounts due to us, will be refunded and we will not have any further liability or responsibility under this Agreement. If the termination is for any reason other than a Dependent's fraud or deception in the use of services or Facilities (or knowingly permitting such fraud or deception by another), we will make this refund within thirty (30) days.

Right to Request Review of Cancellation or Non-Renewal of this Agreement

Any notice we provide You regarding a decision to cancel, terminate or not renew this Agreement will include notice of Your appeal rights, including the right to request review by us or the Department of Managed Health Care if You believe that this Agreement has or will be improperly canceled, rescinded or not renewed. For additional information on these rights, see the part COMPLAINTS AND GRIEVANCES or contact customer service.

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Certification of Prior Creditable Coverage

If Your coverage is terminated, You and Your covered Dependents will receive a certification showing when You were covered under the Agreement. You may need the document to buy, for Yourself or Your family other health coverage. Certifications may be requested within twenty-four (24) months of losing coverage.

You may also request a certification be provided to You, even if You have not lost coverage under this Agreement. If You have any questions, contact the customer service at 1-855- [REDACTED]

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YOUR ELIGIBILITY

HOW YOUR COVERAGE WORKS

Your Agreement provides a wide range of coverage for health care services. The information contained in this part is designed to explain how to access Your benefits. Anthem will cover up to the maximum described below for a Covered Service or supply. Review the SUMMARY OF BENEFITS, the parts WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS for information on Deductibles, Out of Pocket Maximums, Copayments/Coinsurance and any per day, Year or visit limits which may be applied to a particular benefit.

This is a Preferred Provider Organization (PPO) Plan. We provide access to a network of Hospitals and Providers who contract with [REDACTED] to facilitate services to our Members and who provide services at pre-negotiated discounted rates. Benefits for In Network Providers are based on a Maximum Allowed Amount. In Network Providers have an agreement in effect with Anthem and have agreed to accept the Maximum Allowed Amount as payment in full. An In Network Provider may, after notice from us, be subject to a reduced Maximum Allowed Amount in the event the In Network Provider fails to make routine referrals to In Network Providers, except as otherwise allowed (such as for Medical Emergency Services). Out of Network Providers do not have an agreement with Anthem. Your personal financial costs when using Out of Network Providers may be considerably higher than when You use In Network Hospitals or In Network Providers. Further, for certain services there may be no benefit provided when using an Out of Network Provider. You will be responsible for any amount not paid by Anthem when using the services of an Out of Network Provider. Please read the SUMMARY OF BENEFITS and the benefit sections under the part WHAT IS COVERED – MEDICAL carefully to determine these differences. For assistance locating In Network Providers, You may contact us at 1-855-[REDACTED] or access our website at [www.\[REDACTED\]](http://www.[REDACTED])

CHOICE OF IN NETWORK PROVIDER OR OUT OF NETWORK PROVIDER

You have the right to choose an In Network Provider or Out of Network Provider as stated above. Choosing an Out of Network Provider may impact Your personal financial costs. Refer to the SUMMARY OF BENEFITS and the part WHAT IS COVERED - MEDICAL to review Copayment and Coinsurance differences between these types of Providers since Your responsibility is often significantly higher when You use an Out of Network Provider.

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under Your Agreement and that You or Your family member might need:

HOW YOUR COVERAGE WORKS

- 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 Subscriber or select a network Provider. Call Your prospective doctor or clinic, or call A [REDACTED] or by accessing our website at [REDACTED] to ensure that You can obtain the health care services that You need.

In Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers (SCPs)), other professional Providers, Hospitals, and other Facilities who contract with us to care for You.

Referrals are never needed to visit an In Network Specialist including behavioral health Providers.

To see a Physician, call their office:

- Tell them You are an [REDACTED] Member,
- Have Your Identification Card handy. The Physician's office may ask You for Your group or ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Identification Card with You.

Maximum Allowed Amount

The Maximum Allowed Amount is the total reimbursement allowed under this Agreement for Covered Services You receive from In Network Providers, Out of Network 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 the Agreement, then You could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from an Out of Network 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.

HOW YOUR COVERAGE WORKS

In no event do we cover any charge in excess of our Maximum Allowed Amount for any Covered Service or supply.

We have provided two examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only and do not reflect actual benefit amounts under this Agreement.

Example 1: The Plan has the Member Coinsurance Cost Share of 30% for an In Network Provider services after the Deductible has been met. The Member receives services from an In Network surgeon. The charge is \$2,000. The Maximum Allowed Amount under the Plan for the surgery is \$1,000. After the Deductible has been satisfied, Anthem pays 70% when an In Network surgeon is used. This is \$700. The Member's Coinsurance responsibility is 30%, which is \$300. The In Network surgeon accepts the total of \$1,000 as reimbursement for the surgery even though they billed \$2,000.

Example 2: The Plan has the Member Coinsurance Cost Share of 50% for an Out of Network Provider services after the Deductible has been met. The Member receives services from an Out of Network surgeon. The charge is \$2,000. The Maximum Allowed Amount under the Plan for the surgery is \$1,000. After the Deductible has been satisfied, Anthem pays 50% when an Out of Network surgeon is used. This is \$500. The Member's Coinsurance responsibility is also 50%, which is \$500. In addition, the Out of Network surgeon could bill the Member the difference between \$2,000 and \$1,000, so the Member's total out-of-pocket charge would be \$500 plus an additional \$1,000, for a total Member responsibility 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 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.

HOW YOUR COVERAGE WORKS

Provider Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In Network Provider, Out of Network Provider or Other Eligible Provider.

In Network Providers: For Covered Services performed by an In Network Provider, the Maximum Allowed Amount for Your Agreement is the rate the Provider has agreed with ██████████ to accept as reimbursement for the Covered Services. Because In Network 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 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 a Deductible, Copayment, or Coinsurance.

Out of Network Providers and Other Eligible Providers: Providers who have not signed any contract with us and are not in any of our networks are Out of Network Providers. Other Eligible Providers are providers that do not enter into agreements with us such as blood banks, dentist (D.D.S.), dispensing opticians, and respiratory therapists. For Covered Services You receive from an Out of Network Provider or Other Eligible Provider, the Maximum Allowed Amount will be based on the applicable Anthem Out of Network Provider or Other Eligible Provider rate or fee schedule for this Agreement, an amount negotiated by us or a third party vendor which has been agreed to by the Out of Network Provider or Other Eligible Provider, an amount based on or derived from the total charges billed by the Out of Network 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, ██████████ will update such information, which is unadjusted for geographic locality, no less than annually.

Out of Network Providers and Other Eligible Providers may send You a bill and collect the amount of the Out of Network Provider's or Other Eligible Provider's charge that exceeds the Maximum Allowed Amount under this Agreement. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Out of Network Provider charges. This amount can be significant. Customer service is available to assist You in determining Your Agreement's Maximum Allowed Amount for a particular Covered Service from an Out of Network Provider or Other Eligible Provider.

HOW YOUR COVERAGE WORKS

Customer Service 1-855-████████████████████

Please see the part WHAT IS COVERED - MEDICAL for additional information.

Reminder: If You utilize an **In Network Provider**, the Provider **will send us a claim on Your behalf**. If You utilize an Out of Network Provider, the Provider may or may not file a claim on Your behalf.

Member Cost Share

For certain Covered Services, 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 an In Network Provider, Out of Network 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 Out of Network Providers or Other Eligible Providers. See the SUMMARY OF BENEFITS and the part WHAT IS COVERED – MEDICAL for Your Cost Share responsibilities and limitations, or call us at 1-855-3██████████ to learn how this Plan's benefits or Cost Share amounts may vary by the type of Provider You use.

██████████ 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 an In Network Provider, Out of Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this 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 In Network Provider Cost Share percentage when You use an Out of Network Provider. For example, if You go to an In Network Hospital and receive Covered Services from an Out of Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital, You will pay the In Network 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 Out of Network Provider's charge.

HOW YOUR COVERAGE WORKS

Customer Service 1-855- [REDACTED]

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Authorized Referrals

In some circumstances, we may authorize In Network Provider Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out of Network 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 certify an In Network Provider Cost Share amount to apply to a Covered Service received from an Out of Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. Please contact us at 1-855-[REDACTED] for Authorized Referral information or to request authorization.

Reminder: Carry Your identification ("ID") card

Your [REDACTED] ID card identifies You and contains important health care coverage information. Carrying Your ID card at all times will ensure You always have access to this coverage information when You need it. Make sure You show Your ID card to Your doctor, Hospital, pharmacist, or other health care Provider so they know You are covered with Anthem.

HOW YOUR COVERAGE WORKS

As a reminder, refer to the section Emergency Care to understand the differences between obtaining out-of-area Emergency Services within the State of California and for services outside California. Only Emergency Services outside California will utilize the Inter-Plan Arrangements.

Inter-Plan Arrangements

Out-of-Area Services

Anthem covers only Emergency or urgent care services obtained outside of our Service Area.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an

“Inter-Plan Program”), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these programs. These programs include the **BlueCard®** Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when You obtain out-of-area Covered Services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating Providers; and (b) handling interactions with those Providers.

The BlueCard Program allows You to obtain out-of-area Covered Services and supplies from a healthcare Provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for those Covered Services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayments, Coinsurance and/or Deductibles stated in this Agreement.

Whenever You obtain Covered Services or supplies outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay for them, if not a Copayment, is calculated based on the lower of:

- The billed covered charges for the Covered Services or supplies; or
- The Negotiated Price that the Host Blue makes available to Anthem.

HOW YOUR COVERAGE WORKS

Customer Service 1-855- [REDACTED]

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Often, this "Negotiated Price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of 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. But such adjustments will not affect any price that [REDACTED] has already paid for Your claim or Your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate Your liability for any Covered Service or supply according to applicable law.

Non-participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If You need to go to a non-participating out-of-area Provider for Emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that You pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable State law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where You did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of our Service Area. This could happen when the Host Blue's payment for the service would be more than our payment for the service. Also, we may negotiate a payment with such a Provider on an exception basis.

HOW YOUR COVERAGE WORKS

Travel outside the United States – BlueCard Worldwide

If You plan to travel outside the United States, call customer service to find out if Your Agreement has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

When You are traveling abroad and need medical care

You can call the BlueCard Worldwide Service Center any time. They are available twenty-four (24) hours a day, seven (7) days a week. The toll free number is 1-800-810-2583. Or You can call them collect at 1-804-673-1177. An Assistance Coordinator will speak with You and help to set up an appointment with a doctor or Hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for You.

If You need inpatient Hospital care, You or someone on Your behalf, should contact us for Precertification. If You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care.

Refer to the part GETTING APPROVAL FOR BENEFITS to learn how to get Authorization when You need to be admitted to the hospital for Emergency or non-Emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when You arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating Hospital, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctor services;
- Inpatient Hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

HOW YOUR COVERAGE WORKS

Customer Service 1-855- [REDACTED]

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Additional information on BlueCard Worldwide claims:

- You are responsible, at your expense, for obtaining an English language translation of foreign country Provider claims and medical records.
- The exchange rate utilized for:
 - Inpatient Hospital care is based on the date of admission.
 - Outpatient and professional services are based on the date of service.

When You need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

HOW YOUR COVERAGE WORKS

CLAIMS AND PAYMENTS

A claim is incurred on the date the service is provided to You. This is important because You must be enrolled and eligible to receive benefits on the date the service is provided. A claim must be submitted in order for us to record the services and consider them for benefits. We will record claims in our records in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

We only provide benefits for **Covered Services** that are **Medically Necessary**. Benefits and benefit limits are described in WHAT IS COVERED – MEDICAL and in the SUMMARY OF BENEFITS.

Copayments and Coinsurance are outlined in the **SUMMARY OF BENEFITS**. Your Copayment and Coinsurance may be a fixed dollar amount per day, per visit, or it may be a percentage of the Maximum Allowed Amount. It could also be a combination of a fixed dollar amount and a percentage of the Maximum Allowed Amount.

When Covered Services are provided by an Out of Network Provider, You may be responsible for the difference between the Provider's billed charges and the Maximum Allowed Amount. This is not Coinsurance and will not apply to Your Out of Network Out of Pocket Maximums.

These amounts are Your financial responsibility. Copayments are normally paid by or on behalf of the Agreement at the time services are performed. While Your Deductible and/or Coinsurance financial responsibility may also be collected by the Provider at the time services are performed, the Provider may choose to bill You for these services after they have submitted the claim to us. Cost sharing for services with Copayments is the lesser of the Copayment amount or Maximum Allowed Amount.

Described below are the Deductibles, Coinsurance and the Out of Pocket Maximums.

Note: If You replace Your health care coverage from **another health insurance carrier** with this Agreement, we will not apply those Deductibles or Out of Pocket amounts to this Agreement.

Deductibles

Please refer to the SUMMARY OF BENEFITS for services that do not apply to the Deductible.

You have no In Network medical Deductible and In Network Prescription Drug Deductible. Your Out of Network Deductible is a combination of Your Deductible responsibility for Covered Services provided by Out of Network Providers for medical services and Your Out of Network responsibility for Covered services provided by Out of Network Pharmacy Providers for Prescription Drugs.

Amounts for In Network Covered Services and Out of Network Covered Services are applied separately each Benefit Period and cannot be combined.

Each Benefit Period, You must satisfy Your Out of Network Deductibles before we will pay benefits for Out of Network Covered Services.

Your Out of Network medical Deductible and Your Out of Network Prescription Drug Deductible are combined.

Your Out of Network Deductible amount is determined by the number of family members enrolled in this Plan. If only one person is enrolled on the Plan, then only the Out of Network Individual Deductible applies. If more than one person is enrolled, then both Out of Network Individual and Out of Network Family Deductible are applicable as follows:

- Out of Network Individual Deductible: Once the total allowable charges applying to the Out of Network Individual Deductible have been met, no further Out of Network Deductible will be required for the remainder of that Benefit Period.
- Out of Network Family Deductible: Once the total allowable charges applying to the Out of Network Individual Deductible for two (2) or more Members equal the Out of Network Family Deductible, no further Out of Network Deductible will be required for all enrolled Members for the remainder of that Benefit Period.
 - No one Member can contribute more than half of the Out of Network Family Deductible amount towards satisfying the Out of Network Family Deductible amount.

CLAIMS AND PAYMENTS

- If an individual Member has satisfied one half of the Out of Network Family Deductible, this Member has satisfied their Out of Network Individual Deductible for the Benefit Period. The remainder of the Out of Network Family Deductible continues to apply to all other Members on this Plan until the entire Out of Network Family Deductible amount has been satisfied.

The Out of Network Deductible amounts are listed in the SUMMARY OF BENEFITS.

The automatic enrollment of a Newborn or Adopted Children may cause the applicable Deductible to automatically change from an Individual Deductible to a Family Deductible. Additional information on Newborn or Adopted Children is explained in the part YOUR ELIGIBILITY.

During each Benefit Period, each Member is responsible for Covered Services incurred up to the Deductible amounts. **These Deductibles are not prorated for a partial Year.** Only Covered Services will apply toward the Deductibles. A claim must be submitted in order for us to record Your eligible covered Deductible expense. We will record Your Deductibles in our files in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

If You submit a claim for services which have a maximum payment limit and neither of Your Deductibles are satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward Your In Network Provider or Out of Network Provider Deductible, whichever applies.

Your Deductibles for Covered Services will apply towards Your **Out of Pocket Maximums.**

Coinsurance

Coinsurance is the percentage amount of the Maximum Allowed Amount that You are responsible for as stated in the SUMMARY OF BENEFITS. For Out of Network services, after Your Out of Network Deductible has been satisfied, You will be required to pay Coinsurance for services received while You are covered under this Plan.

When Covered Services are provided by an Out of Network Provider, You may be responsible for the difference between the Provider's billed charges and the Maximum Allowed Amount. This is not Coinsurance and will not apply to Your Out of Network Out of Pocket Maximum.

Out of Pocket Maximums

The In Network and Out of Network Out of Pocket Maximums include all Deductibles, Coinsurance and Copayments You pay during a Benefit Period for all Essential Health Benefits, medical services, pediatric vision and Prescription Drug services combined. It does not include charges over the benefit limits, over the Maximum Allowed Amount, Precertification Copayments or amounts You pay for non Covered Services.

The In Network and Out of Network Out of Pocket Maximums are separate and do not apply toward each other.

In Network Out of Pocket Maximums

After You have satisfied the In Network Out of Pocket Maximums, Anthem will provide benefits at 100% of the Maximum Allowed Amount for In Network Covered Services. If only one person enrolled on the Plan, then only the In Network Individual Out of Pocket Maximum applies. If more than one person enrolled, then both In Network Individual Out of Pocket Maximum and In Network Family Out of Pocket Maximum are applicable as follows:

- In Network Individual Out of Pocket Maximum: Once the total allowable charges applying to the In Network Individual Out of Pocket Maximum have been met, no further In Network Copayments/Coinsurance will be required for In Network Covered Services for the remainder of that Benefit Period.

- In Network Family Out of Pocket Maximum: Once the total allowable charges applying to the In Network Family Out of Pocket Maximum have been met, no further In Network Copayments/Coinsurance will be required for In Network Covered Services for the remainder of that Benefit Period.
 - If an individual Member has satisfied one half of the In Network Family Out of Pocket Maximum, this Member has satisfied their In Network Individual Out of Pocket Maximum for that Benefit Period.
 - No one Member can contribute more than half of the In Network Family Out of Pocket Maximum amount towards satisfying the In Network Family Out of Pocket Maximum.
 - The In Network Family Out of Pocket Maximum continues to apply to all other Members on this Plan until the entire In Network Family Out of Pocket Maximum amount has been satisfied.

The In Network Out of Pocket Maximum amounts are listed in the SUMMARY OF BENEFITS.

Out of Network Out of Pocket Maximum

After You have satisfied the Out of Network Out of Pocket Maximum, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Out of Network Covered Services. If only one person enrolled on the Plan, then only the Out of Network Individual Out of Pocket Maximum applies. If more than one person enrolled, then both Out of Network Individual Out of Pocket Maximum and Out of Network Family Out of Pocket Maximum are applicable as follows:

- Out of Network Individual Out of Pocket Maximum: Once the total allowable charges applying to the Out of Network Individual Out of Pocket Maximum have been met, no further Out of Network Copayments/Coinsurance will be required for Out of Network Covered services for the remainder of that Benefit Period.
- Out of Network Family Out of Pocket Maximum: Once the total allowable charges applying to the Out of Network Family Out of Pocket Maximum have been met, no further Out of Network Copayments/Coinsurance will be required for the remainder of that Benefit Period.
 - If an individual Member has satisfied one half of the Out of Network Individual Out of Pocket Maximum, this Member has satisfied their Out of network Individual Out of Pocket Maximum for that Benefit Period.
 - No one Member can contribute more than half of the Out of Network Family Out of Pocket Maximum amount towards satisfying the Out of Network Family Out of Pocket Maximum.
 - The Out of Network Family Out of Pocket Maximum continues to apply to all other Members on this Plan until the entire Out of Network Family Out of Pocket Maximum amount has been satisfied.

The Out of Network Out of Pocket Maximum amounts are listed in the SUMMARY OF BENEFITS.

CLAIMS AND PAYMENTS

Customer Service 1-855-383-7247 or www.anthem.com/ca

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The automatic enrollment of a Newborn or Adopted Children may cause the applicable Out of Pocket Maximum to automatically change from the Individual Out of Pocket Maximum to a Family Out of Pocket Maximum. Additional information on Newborn or Adopted Children is explained in the part YOUR ELIGIBILITY.

Specimen

CLAIMS AND PAYMENTS

WHAT IS COVERED – MEDICAL

This part describes the **Covered Services** available under Your Agreement. Covered Services are subject to all the terms and conditions listed in this Agreement, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements. Please read the SUMMARY OF BENEFITS for details on the amounts You must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read HOW YOUR COVERAGE WORKS for more information on Your Agreement's rules. Read WHAT IS NOT COVERED (Exclusions) – MEDICAL for important details on excluded services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find.

Note: Several sections may apply to Your claims. For example, if You have surgery, benefits for Your Hospital stay will be described under "Surgery" and "Inpatient Facility Services." Benefits for Your Physician's services will be described under "Office Visits." As a result, You should read all sections that might apply to Your claims.

You should also know that many Covered Services can be received in several settings, including a Physician's office, an urgent care services, an Outpatient Facility Services, or an Inpatient Facility Services. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay. Please see the SUMMARY OF BENEFITS for more details on how benefits vary in each setting.

For a list of services and supplies that are not covered by this Agreement, and important details on excluded services, please refer to WHAT IS NOT COVERED (Exclusions) – MEDICAL and WHAT IS NOT COVERED – PRESCRIPTION DRUGS.

THIS AGREEMENT ONLY COVERS SERVICES AND SUPPLIES THAT ARE **MEDICALLY NECESSARY**. [REDACTED] RESERVES THE RIGHT TO REVIEW SERVICES AND/OR SUPPLIES TO DETERMINE IF THEY ARE MEDICALLY NECESSARY PRIOR TO THOSE SERVICES BEING RENDERED (PRECERTIFICATION), WHILE SERVICES ARE BEING RENDERED (ADMISSION REVIEW OR CONTINUED STAY REVIEW), OR AFTER SERVICES HAVE BEEN PROVIDED (RETROSPECTIVE REVIEW). PLEASE REFER TO THE DEFINITIONS FOR A DEFINITION OF MEDICALLY NECESSARY. ADDITIONAL INFORMATION ON THE REVIEW PROCESS IS AVAILABLE IN THE PART GETTING APPROVAL FOR BENEFITS OR CALL CUSTOMER SERVICE.

Customer Service 1-855- [REDACTED]

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You must satisfy the In Network or Out of Network medical Deductible before we will make payment for services You receive, except for certain services as stated in this sections below. Additionally, the medical Deductible is explained in the SUMMARY OF BENEFITS.

Any limits on the number of visits or days covered are stated under the specific benefit and also listed in the SUMMARY OF BENEFITS. These benefits are subject to all other provisions of this Agreement as well, which may also limit benefits or result in benefits not being payable.

Specimen

WHAT IS COVERED – MEDICAL

Acupuncture

Please see "Therapy Services" later in this part.

Allergy Services

Please see "Office Visits" and "Office Visits – Additional Services in an Office Setting" later in this part.

Ambulance Services (Ground, Air and Water)

Precertification is required for all non Emergency ambulance transportation (see the part GETTING APPROVAL FOR BENEFITS for details).

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and/or injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non emergency ambulance transportation, including psychiatric transportation for safety issues. This includes ground, water, fixed wing and rotary wing air transportation. Ambulance Services do not include transportation by car, taxi, bus, gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.
- For ground ambulance, You are taken:
 - From Your home, scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital; or
 - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
 - From the scene of an accident or Medical Emergency to a Hospital;
 - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital
 - Between a Hospital and an approved Facility.

WHAT IS COVERED – MEDICAL

You must be taken to the nearest Facility that can give care for Your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Emergency Response Ambulance Services

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if You are not taken to a Facility. If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if You are not transported to a Hospital. 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.

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 AN EMERGENCY, YOU SHOULD CALL 911 OR GO DIRECTLY TO THE NEAREST HOSPITAL EMERGENCY ROOM.

Ground Ambulance

Services are subject to Medical Necessity review by Anthem. All scheduled ground ambulance service for non-Emergency transports, not including acute Facility to acute Facility transport, requires Precertification.

Air and Water Ambulance

Air Ambulance Services are subject to Medical Necessity review by Anthem. We retain the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation. Air ambulance services for non-Emergency Hospital to Hospital transports require Precertification.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Agreement will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats You cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician.

Fixed Wing Air Ambulance

Fixed wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because Your condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by fixed wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Rotary Wing Air Ambulance

Rotary wing air ambulance is furnished when the Member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the Member's condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider.

Autism

Benefits for Covered Services for the treatment of Autism are provided on the same basis as any other medical condition. Please see "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" later in this part.

Bariatric Surgery

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" later in this part.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

Precertification is required for all services related to Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (see the part GETTING APPROVAL FOR BENEFITS for details).

Benefits for Covered Services and supplies provided for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism are subject to the same cost-sharing provisions as other medical services or Prescription Drugs covered by this Plan, except as specifically stated in this section. These benefits are subject to all other terms, conditions, limitations and exclusions, including WHAT IS COVERED – MEDICAL.

Our Provider network will be limited to certain Qualified Autism Service Providers who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer Behavioral Health Treatment for a Provider that has contracted with Anthem.

For purposes of this section Behavioral Health Treatment means 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 criteria:

- A. The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- B. The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
 - i. A Qualified Autism Service Provider.
 - ii. A Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider.
 - iii. A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider.
- C. The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with applicable State law that imposes requirements on the provision of Behavioral Health Treatment services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - i. Describes the patient's behavioral health impairments to be treated.

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- ii. Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
 - iii. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism.
 - iv. Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- D. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Anthem upon request.

For purposes of this section 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.

For purposes of this section 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 forty (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.

For purposes of this section Pervasive Developmental Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders includes:

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified

For purposes of this section 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, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language

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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.

For purposes of this section 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.

For purposes of this section 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.

Conditions of Services

- Coverage is not provided for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program.
- The treatment plan shall be made available to Anthem upon request.
- Coverage is limited to Behavioral Health Treatment.

Cardiac Rehabilitation Therapy

Please see "Therapy Services" later in this part.

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

Precertification is required for all services related to Human Organ and Tissue Transplants and Bariatric Surgery (see the part GETTING APPROVAL FOR BENEFITS for details).

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

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

Note: An In Network Provider is not necessarily a CME Facility. Information on CME Facilities can be obtained by calling 1-855-██████████

Bariatric Surgery (requires Precertification): 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 Precertification for all bariatric surgical procedures. Precertification can be obtained by calling toll free 1-800-██████████. When You or Your Physician calls for the required Precertification, we will advise You that such services must be performed at a CME Facility.

Note: Charges for these bariatric surgical procedures and related services are covered only when the bariatric surgical procedures and related services are performed at a CME Facility.

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

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

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at 1-855-██████. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

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

- the recipient or
- the donor

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

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

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's place of residence.
- Lodging, limited to one room, double occupancy.
- Meals, tobacco, alcohol, Drug expenses and other non-food items are excluded.

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

When You request reimbursement of covered travel expenses, You must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call customer service at 1-855-383-7247 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 items; child care; mileage within the city where the CME is located, rental cars, buses, taxis or shuttle services, except as specifically approved by us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related, or a direct result, of the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver; or return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Searches

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

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

Chemotherapy

Please see "Therapy Services" later in this part.

Clinical Trials

Benefits include coverage for services given to You as a participant in an approved Clinical Trial if the services are Covered Services under this Plan. An “approved Clinical Trial” means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below:
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an Investigational new Drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for Drug trials which are exempt from the Investigational new Drug application.

Your Plan may require You to use an In Network Provider to utilize or maximize Your benefits.

When a requested service is part of an approved Clinical Trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for Clinical Trials services that are not part of approved Clinical Trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Anthem is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- The Investigational item, device, or service, itself; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Please note: This Agreement does not include coverage for the Pediatric Dental Essential Health Benefits. [Mandatory Pediatric Dental is in a separate policy]

Preparing the Mouth for Medical Treatments

Your Agreement includes coverage for Dental Services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Orthognathic (jawbone) surgery
- Dental X-rays
- Extractions, including surgical extractions
- Anesthesia

Admissions for dental care up to three (3) days of inpatient Hospital services when a Hospital stay is Medically Necessary.

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Agreement.

Benefits are available for the services of a Physician 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.

General anesthesia and associated Facility charges for dental procedures in a Hospital or Ambulatory Surgery Center is covered if the Member is:

- Under seven (7) years of age; or
- Developmentally disabled regardless of age; or
- The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

Medically Necessary dental or orthodontic services are covered if they are integral to 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 Agreement, an In Network 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 Agreement, please call customer service at 1-855-383-7247.

Diabetes Equipment, Education and Supplies

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:

1. The following Diabetes Equipment and Supplies
 - Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips
 - Insulin Pumps and all related necessary supplies
 - Pen delivery systems for Insulin administration
 - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications
 - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin

Note: This equipment and supplies are covered under Your Agreement's benefits for the section Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics, and Medical and Surgical Supplies.

2. Diabetes Outpatient Self-Management Training Program, which:
- is designed to teach the Member who is a patient, and the patient's family, about the disease process and the daily management of diabetic therapy;
 - includes self-management training, education and medical nutrition therapy to enable the Member to properly use the equipment, supplies and medications necessary to manage the disease;
 - Is supervised by a Physician

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

3. The following medications and supplies are covered under WHAT IS COVERED – PRESCRIPTION DRUGS:
- Insulin, glucagon and other Prescription Drugs for the treatment of diabetes
 - Insulin syringes
 - Urine testing strips and lancet puncture devices.

Note: These items must be obtained either from a retail Pharmacy or through the mail order Prescription Drug program.

4. Screening for gestational diabetes and Type 2 Diabetes Mellitus are covered under "Preventive Care" later in this part.

Diagnostic

Specific diagnostic procedures, including advance imaging procedures, wherever performed, require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

Diagnostic Services

Your Agreement includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Physician and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

- Diagnostic Laboratory and Pathology Services

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- Diagnostic Imaging Services and Electronic Diagnostic Tests
 - X-rays / regular imaging services
 - Ultrasound
 - Electrocardiograms (EKG)
 - Electroencephalography (EEG)
 - Echocardiograms
 - Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
 - Tests ordered before a surgery or admission.
- Advanced Diagnostic Imaging Services
Benefits include but are not limited to:
 - Computed Tomography (CT) scan
 - Computed Tomography Angiography (CTA) scan
 - Magnetic Resonance Imaging (MRI) scan
 - Magnetic Resonance Angiogram (MRA) scan
 - Magnetic Resonance Spectroscopy (MRS) scan
 - Nuclear Cardiology (NC) scan
 - Positron Emission Tomography (PET) scans
 - PET/CT Fusion scans
 - Quantitative Computed Tomography (QCT) Bone Densitometry
 - Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see "Therapy Services" later in this part.

Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies

Specific medical supplies and equipment require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

Covered Services are subject to change. For a list of current Covered Services, please call customer services at 1-855-██████████

Durable Medical Equipment and Medical Devices

Your Agreement includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable
- Is used for a medical purpose and is of no further use when medical need ends
- Is meant for use outside a medical Facility
- Is only for the use of the patient
- Is made to serve a medical use
- Is ordered by a Physician

Benefits include purchase only equipment and devices (e.g., crutches and customized equipment), purchase or rent to purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it. We cover the following durable medical equipment for use in your home (or another location used as your home):

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns

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Customer Service 1-855-[REDACTED]

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- Non-segmental home model pneumatic compressor for the lower extremities

Orthotics and Special Footwear [\[Learn more\]](#)

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements 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, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications

Covered Services include determining if You need the device, initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device.

Specimen

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Prosthetics and Devices

Your Agreement includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes
- Breast prosthesis (whether internal or external) after a Medically Necessary mastectomy, as required by the Women's Health and Cancer Rights Act. Custom-made prostheses when Medically Necessary and up to three (3) brassieres required to hold a prosthesis every twelve (12) months
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect
- Colostomy supplies
- Restoration prosthesis (composite facial prosthesis)
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy
- Cochlear implants

Medical and Surgical Supplies

Your Agreement includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Blood and Blood Products

Your Agreement includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank. Benefits include Hospital services for blood, blood plasma, blood derivatives and blood factors, and blood transfusions, including blood processing and storage costs.

Ostomy and Urological Supplies

Your Agreement includes coverage for ostomy and urological supplies soft goods formulary (listed in the generic):

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service, but You may have to pay the difference between the Out of Network Provider's charge and the Maximum Allowed Amount for services received outside of California. An Out of Network ambulance Provider may also bill You for the charges in excess of the Reasonable and Customary Value.

The Maximum Allowed Amount for Emergency Care from an Out of Network Provider will be the Reasonable and Customary Value.

Emergency Services

Benefits are available for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in:

1. placing the patient's health in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures.

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

Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

1. an immediate danger to himself or herself or to others, or
2. immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Care

"Emergency Care" means a medical exam including services routinely available to evaluate an Emergency Medical Condition. It includes any further medical exams and treatment required to stabilize the patient.

If You are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether You get care from an In Network or Out of Network Provider. Emergency Care You get from an Out of Network Provider will be covered as an In Network service, but You may have to pay the difference between the Out of Network Provider's charge and the Maximum Allowed Amount for services received outside of California. An Out of Network ambulance Provider may also bill You for the charges in excess of the Reasonable and Customary Value.

The Maximum Allowed Amount for Emergency Care from an Out of Network Provider will be the Reasonable and Customary Value.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your Physician calls us as soon as possible. See the part GETTING APPROVAL FOR BENEFITS for more details. If You or Your Physician do not call us, You may have to pay for services that are not Medically Necessary.

Treatment You get after Your condition has stabilized is not Emergency Care. If You continue to get care from an Out of Network Provider, Covered Services will be covered at the Out of Network level unless we agree to cover it as an Authorized Service.

Habilitation Services

Please see "Rehabilitation and Habilitation Services" later in this part.

Health Education

Health education counseling, programs and material to help You take an active role in protecting and improving your health, including programs for tobacco cessation and stress management.

Home Care Services

Precertification is required for Home Care Services (see the part GETTING APPROVAL FOR BENEFITS for details).

Benefits are available for Covered Services performed by a Home Health Care Agency or other professional Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be


prescribed by a Physician and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff. Covered Services include but are not limited to:

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

Limitations:

- Out of Network Providers are limited to 100 visits per Benefit Period
- Limited to up to two (2) hours per visit for visits by a nurse, medical social worker or physical, occupational, or speech therapist and up to four (4) hours per visit for visits by a home health aide.
- Up to three (3) visits per day.
- The ordering Physician must be treating the illness or injury necessitating the Home Health Care and renew the order for these services once every thirty (30) days.
- Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.
- We will not cover personal comfort items.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the  palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Hospice Care is available for two (2) ninety (90) day periods, followed by an unlimited number of subsequent sixty (60) day periods.
- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.

WHAT IS COVERED – MEDICAL

- Short-term inpatient Hospital care when needed in periods of crisis.
- Short-term inpatient Hospital care as respite care. Inpatient respite care is limited to a maximum of five (5) consecutive days per admission.
- Skilled nursing services, home health aide services and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation
- Physical Therapy, Occupational Therapy, speech therapy and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than twelve (12) months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of Your care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care are available to the Member in Hospice. These additional Covered Services will be covered under other sections of this part.

Limitations:

The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services that are not under the supervision of a registered nurse
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services
- Services provided by volunteers

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" earlier in this part.

Infusion Therapy

Please see "Therapy Services" later in this part.

Inpatient Facility Services

Precertification is required for all inpatient Facility admissions (except inpatient Hospital stays for the delivery of a child or mastectomy surgery) (see the part GETTING APPROVAL FOR BENEFITS for details).

Inpatient Facility Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most Anthem will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation Facilities are available.
- A room in a Special Care Unit approved by us. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia and oxygen supplies and services given by the Hospital.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when asked for by Your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity Care

Maternity Services

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

Covered Services include services needed during a normal or Complicated Pregnancy and services needed for a miscarriage including:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the Newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent and screening of a Newborn for genetic diseases provided through a program established by law or regulation;
- Prenatal and postnatal services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus. Prenatal genetic testing for specific genetic disorders for which genetic counseling is available; and
- Participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's State Department of Health Services.

WHAT IS COVERED – MEDICAL

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or Newborn to less than forty-eight (48) hours after vaginal birth, or less than ninety-six (96) hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get Precertification from us before prescribing a length of stay which is not more than forty-eight (48) hours for a vaginal birth or ninety-six (96) hours after a C-section.

Abortion Services

Benefits include services for a therapeutic abortion, which is a Medically Necessary abortion recommended by a Provider and may include the termination of a pregnancy to save the life or health of the mother; prevent harm to the women's health; where indications are that the child will have a significantly increased chance of premature morbidity or mortality; or to selectively reduce the number of fetuses to lessen health risks associated with multiple pregnancy. Benefits for therapeutic abortions include any abortion for the termination of a pregnancy resulting from rape or incest.

Mental Health and Substance Abuse (Chemical Dependency) Services

Precertification is required for Facility services (see the part GETTING APPROVAL FOR BENEFITS for details).

(See the "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section for coverage and Precertification requirements for those services.)

We cover services specified in this section only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder." For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

Covered Services for Mental and Nervous Disorders, including Severe Mental Illness and Serious Emotional Disturbances of a Child, in this section shall meet or exceed that required by law. Covered Services include, but are not limited to the following:

- Inpatient Services in a Hospital or any Facility that we must cover per State law. Inpatient benefits include psychiatric hospitalization, psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.
- Outpatient Services including treatment in an outpatient department of a Hospital and Office Visits.
- Day Treatment Services which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center or intermediate care Facility. It offers individualized and intensive treatment and includes:
 - Observation and assessment by a psychiatrist weekly or more often,
 - Rehabilitation, therapy, education, and recreational or social activities.
- Physician visits during a covered inpatient stay and for outpatient psychotherapy or outpatient psychological testing.
- Methadone maintenance treatment
- Behavioral health treatment for Pervasive Developmental Disorder or autism. Inpatient and outpatient Facility services are covered under this section. See the "Pervasive Developmental Disorder or Autism" section for a description of additional services that are covered.

Note: You must obtain Precertification 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 Precertification is not obtained (see the part GETTING APPROVAL FOR BENEFITS section for details).

Covered Services do not include programs to stop smoking, or to help with nicotine or tobacco abuse.

Occupational Therapy

Please see "Therapy Services" later in this part.

Office Visits

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

- History-Gathering of information on an illness or injury.
- Examination
- Physician's medical decision regarding the diagnosis and treatment plan.

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 services performed other than the three services specifically listed above.

Covered Services include:

- Office Visits with Primary care Physicians and Providers (PCP) and Specialty Care Physicians and Providers
- Home Visits for medical care to examine, diagnose, and treat an illness or injury.

Note: Physician visits in the home are different than the "Home Care Services" benefit described earlier in this Agreement

- Retail Health Clinic Visit for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children
- Walk-In Physician's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Physician's office
- Urgent Care as described in "Urgent Care" later in this part
- Online Care Visits when available in Your area. Covered Services include a medical visit with the Physician using the internet by a webcam, chat or voice. Online care visits do not include reporting normal lab or other test results, requesting Office Visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to Physicians outside the online care panel, benefit Precertification, or Physician to Physician discussions
- Telehealth as described in "Telehealth" later in this part.

WHAT IS COVERED – MEDICAL

- After Hours Care. If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency room (see the part WHAT IS NOT COVERED (Exclusions) – MEDICAL). This exclusion does not apply to Emergency Services.
- 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 will be provided according to the benefits, limitations and exclusions of this Agreement. If You wish to receive a second medical opinion, remember that greater benefits are provided when You choose an In Network Provider. You may also ask Your Physician to refer You to an In Network Provider to receive a second opinion.

Office Visits – Additional Services in an Office Setting

Additional services received during an Office Visit include, but are not limited to:

- Injection administration, including allergy serum
- Diagnostic laboratory and pathology services
- Diagnostic imaging services and electronic diagnostic tests
- Advanced diagnostic imaging services
- Office surgery
- Prescription Drugs for the Drug itself dispensed in the office through infusion or injection

Orthotics

Please see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this part.

Osteoporosis

Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Outpatient Facility Services

Precertification is required for all outpatient Facility admissions and specific outpatient services, including diagnostic treatment and other services (see the part GETTING APPROVAL FOR BENEFITS for details).

Your Agreement includes Covered Services in an:

- Outpatient Hospital, including ambulatory care and Physician services,
- Ambulatory Surgical Center,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us

Benefits include Facility and related (ancillary) charges, when Medically Necessary, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs dispensed through the Facility,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services include Physical, Speech and Occupational Therapy

Pediatric Vision Services

Please see "Vision Services" later in this part.

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 Anthem. 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. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under Your Plan's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

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

- Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified Health Professionals with expertise in the treatment and care of PKU, and
- 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

Physical Therapy

Please see "Therapy Services" later in this part.

Preventive Care

Preventive care is given during an Office Visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and State law. Preventive care services stated below are covered by this Agreement with no Deductible, Copayments or Coinsurance when You use an In Network Provider. That means ██████ pays 100% of the Maximum Allowed Amount. If obtained from an Out of Network Provider, the Member will pay 40% of the Maximum Allowed Amount. Covered Services fall under four broad categories as shown below:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer,
 - b. Cervical cancer,
 - c. Colorectal cancer,
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. 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 listed in the guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including:

WHAT IS COVERED – MEDICAL

- a. Women's contraceptives, sterilization procedures and counseling. This includes Generic contraceptive Drugs (unless there is no Generic equivalent) obtained from an In Network Pharmacy, as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), cervical caps and implants are also covered. Brand Name Drugs (with a Generic equivalent) will be covered under the Prescription Drug Benefit subject to the applicable Prescription Drug Deductible, Copayment and/or Coinsurance amounts as described in the SUMMARY OF BENEFITS. Also see the part WHAT IS COVERED – PRESCRIPTION DRUGS.
- b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) pump per pregnancy or as required by law. Breast pumps are covered under Your Agreement's medical benefits.
- c. Gestational diabetes screening.
- d. Well woman visits that are age and developmentally appropriate, including preconception and prenatal care.
- e. Screening and counseling for sexually transmitted infections.
- f. Screening and counseling for Human Immunodeficiency Virus (HIV).
- g. Screening and counseling for interpersonal and domestic violence.
- h. Testing for Human Papillomavirus (HPV).

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- 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.
- 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.
- Human papillomavirus (HPV) test for cervical cancer.

Adult Preventive Care

- Routine physical exams.

WHAT IS COVERED – MEDICAL

- 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 Members age 19 and above.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.
- 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.

You may call customer service at 1-855-383-7247 for more details about these services or view the federal government's websites: <http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov/clinic/uspstfix.htm>, and <http://www.cdc.gov/vaccines/recs/acip/>.

Prosthetics

Please see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this part.

Pulmonary Therapy

Please see "Therapy Services" later in this part.

Radiation Therapy

Please see "Therapy Services" later in this part.

Rehabilitation and Habilitation Services

Precertification is required for a Skilled Nursing Facility, Physical therapy, speech therapy, Occupational Therapy and Mental Health services (see the part GETTING APPROVAL FOR BENEFITS for details).

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, Physical, Occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals You can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and You stop progressing toward those goals.

Habilitation services means Medically Necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitation services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care or education services of any kind, including, but not limited to, vocational training. Habilitation services shall be covered under the same terms and conditions applied to rehabilitation services under the Agreement.

Respiratory Therapy

Please see "Therapy Services" later in this part.

Residential Treatment Center

Please see "Inpatient Facility" in this part.

Skilled Nursing Facility

Precertification is required for Skilled Nursing Facility admissions and services (see the part GETTING APPROVAL FOR BENEFITS for details).

When You require inpatient skilled nursing and related services for convalescent and Rehabilitative Care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

We cover the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Physician as part of Your plan of care in the Skilled Nursing Facility
- Durable Medical Equipment if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical Social Services
- Blood, blood products and their administration
- Medical Supplies
- Physical, Occupational and speech therapy
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Respiratory therapy

Limitations:

- Out of Network Providers are limited to 100 days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A Skilled Nursing Day Allowance ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends. A prior three-day stay in an acute care hospital is not required to commence a Skilled Nursing Day Allowance.
- You must be under active supervision of a Physician treating Your illness or injury.

WHAT IS COVERED – MEDICAL

Speech Therapy

Please see "Therapy Services" later in this part.

Surgery

Specific surgical procedures, wherever performed, require Precertification (see the part GETTING APPROVAL FOR BENEFITS for details).

Your Agreement covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Medically Necessary operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Bariatric Surgery

Please see "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" earlier in this part.

Oral Surgery

Note: Although this Agreement covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate;
- Orthognathic (jawbone) surgery for a medical condition or injury which prevents normal function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone.
- Oral / surgical correction of Accidental Injuries.
- Treatment of lesions, removal of tumors and biopsies.

- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Please see "Dental Services" earlier in the part for more information.

Reconstructive Surgery

Benefits include Reconstructive Surgery to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to the extent possible. Benefits also include surgery performed to restore symmetry after a mastectomy.

Mastectomy and Lymph Node Dissections

Members who are getting benefits for a mastectomy or for Follow-Up Care for a mastectomy and who choose breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Agreement.

Telehealth

Benefits are provided for Covered Services that are appropriately provided through Telehealth, subject to the terms and conditions of this Agreement. 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 does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine, or electronic mail.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Precertification is required for many therapy services including: Physical therapy, speech therapy, Occupational Therapy and Infusion Therapy (in all settings) (see the part GETTING APPROVAL FOR BENEFITS for details).

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve Your level of function within a reasonable period of time. Physical Therapy and Occupational Therapy must be provided by a Physician. Covered Services include:

- Physical Therapy – The treatment by a physical method to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes the use of heat, cold, exercise, electricity, ultraviolet, massage and aquatic therapy (as part of a Physician Therapy treatment plan) to improve circulation, strengthen muscles, encourage return of motion to treat the following:
 - neurological surgery
 - orthopedic surgery
 - cerebral vascular accident
 - third degree burns
 - head trauma
 - spinal cord injury
- Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment.
- Occupational Therapy – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational Therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- Acupuncture – Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. Subject to the following:

WHAT IS COVERED – MEDICAL

- Acupuncture must be provided by a Physician.
- All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

Infusion Therapy

Physician prescribed Infusion Therapy for a period of ninety (90) days or less (each course of therapy must be Medically Necessary).

- If services are performed in the home, those services must be billed by and performed by a Provider licensed by State and local laws.
- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- Durable, reusable supplies, and durable medical equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Limitations:

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to Investigational use" or Drugs prescribed for Experimental use.
 - If Anthem determines that the requested Drug, device, procedure, or therapy is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. Refer to the part INDEPENDENT MEDICAL REVIEW.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges, including the preparation of the finished product, by an Out of Network Provider that exceeds the Prescription Drug Maximum Allowed Amount.
- Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Plan.

Other Therapy Services

Benefits are available for:

- Cardiac Rehabilitation – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- Chemotherapy – Treatment of an illness by chemical or biological antineoplastic agents.
- Dialysis – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home Hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis. We also cover equipment and medical supplies required for home Hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment of supplies that adequately meets Your medical needs.
- Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore Your health after an illness or injury.
- Radiation Therapy – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- Respiratory Therapy – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see “Center for Medical Excellence (CME) for Transplants and Bariatric Surgery” earlier in this part.

Urgent Care Services

Urgent care benefits are for those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a woman or her unborn child.

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye, including contact lenses to treat aphakia (for Members through age 9) and aniridia. Vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Vision Services - Pediatric

Vision Care that is Covered:

The following vision care benefits are available to Members through age 18. We will cover vision care that is listed in this section. See Your SUMMARY OF BENEFITS for the benefit frequencies and Your Cost Share amounts for covered vision care. We will not pay for vision care listed in the part WHAT IS NOT COVERED (Exclusions) – MEDICAL under "Vision Care."

Routine Eye Exam

Your Agreement covers a complete eye exam with dilation as needed. The exam is used to check all aspects of Your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

You have a choice in Your eyeglass lenses. Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromatic lenses are also covered at no extra cost.

Covered eyeglass lenses include standard plastic (CR39) or glass lenses up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)

WHAT IS COVERED – MEDICAL

- progressive

Frames

- We offer a selection of frames that are covered under this Agreement
- Frames are limited to Once every Benefit Period

Elective Contact Lenses

- A one (1) Year supply of contact lenses is covered every Benefit Period (applicable to certain contact lenses within the formulary).
- Elective contact lenses are contacts that You choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of Your eyeglass lenses benefit. We offer a selection of contact lenses that are covered under this Agreement

Non-Elective Contact Lenses

- Contact lenses for Aniridia will be covered up to two (2) contact lenses per eye (including fitting and dispensing) per Benefit Period
- Contact lenses for Aphakia will be covered up to six (6) contact lenses per eye (including fitting and dispensing) per Benefit Period
- Non-elective contacts are only provided for the following medical conditions:
 - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
 - High Ametropia exceeding -12D or +9D in spherical equivalent.
 - Anisometropia of 3D or more.
 - Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in the SUMMARY OF BENEFITS.

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the remaining usable vision for our Members with low vision.

Low vision benefits include:

- Comprehensive Low Vision Exam

WHAT IS COVERED – MEDICAL

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- Optical/Non-optical aids
- Supplemental testing

Specimen

WHAT IS COVERED – MEDICAL

WHAT IS NOT COVERED (Exclusions) – MEDICAL

This list of services and supplies are excluded from Your medical coverage under this Plan and will not be covered in any case. Your Prescription Drug benefits are explained in the part WHAT IS COVERED – PRESCRIPTION DRUGS. Exclusions for Prescription Drugs are explained in the part WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Abortion: Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother.

Acts of **War**, Disasters, or Nuclear Accidents: In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give You Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. This exclusion does not apply to acts of terrorism.

Administrative Charges

- Charges to complete claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples include, but are not limited to, fees for educational brochures or calling You to give You test results.

Affiliated Providers: Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

After Hours or Holiday Charges: Coverage is not provided for additional charges beyond the Maximum Allowed Amount for basic and primary services for services requested after normal Provider service hours or on holidays. This exclusion does not apply to Emergency Services.

Alternative/Complementary Medicine: Unless covered under WHAT IS COVERED – MEDICAL or WHAT IS COVERED – PRESCRIPTION DRUGS, coverage is not provided for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless part of a Physical Therapy treatment plan), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Artificial/Mechanical Devices (Heart Condition): includes services related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Breast Reduction/Augmentation: Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes unless the removal or replacement is due to complications resulting from cosmetic breast augmentation. Augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer. No coverage is provided for surgical treatment of gynecomastia, unless Medically Necessary. Breast reduction is covered only if Medically Necessary.

Before Effective Date or After Termination Date: Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

Charges Over the Maximum Allowed Amount: Charges over the Maximum Allowed Amount for Covered Services.

Chiropractic Services: Chiropractic services.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Cosmetic Services: Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how You look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of Your skin or to change the size, shape or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts).

This exclusion does not apply to Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.

Counseling Services: religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

Court Ordered Care: to include testing or care, unless Medically Necessary and Precertified (see the part GETTING APPROVAL FOR BENEFITS for details).

Crime: Treatment of an injury or illness that results from a crime You committed, or tried to commit. This Exclusion does not apply if You were the victim of a crime, including domestic violence.

Custodial Care, Services/Care Other Facilities: Coverage is not provided for assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice Care, Skilled Nursing Facility or inpatient Hospital care.

Dental implants for Member age nineteen (19) and over: (material implanted into or on bone or soft tissue) or any associated procedure as part of the implantation or removal of implants unless specifically stated as a Covered Service.

Dental Services: All Dental Services except as stated under the part WHAT IS COVERED – MEDICAL.

Dental X Rays, Supplies & Appliances: and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Devices that are:

- Not generally accepted under professional medical standards as being safe, effective or whose use is in question even though they are approved by the federal Food and Drug Administration.
- Not approved by the federal Food and Drug Administration.

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

Disposable Supplies for home use. Bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion shall not apply to disposable supplies covered in WHAT IS COVERED – MEDICAL in the sections "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies," "Home Care Services" and "Hospice Care," and WHAT IS COVERED – PRESCRIPTION DRUGS.

Drugs, medications or other substances that are:

- Not generally accepted under professional medical standards as being safe, effective or whose use is in question even though they are approved by the federal Food and Drug Administration.
- Not approved by the federal Food and Drug Administration.
- Dispensed or administered in any setting except as specifically stated in the part WHAT IS COVERED – PRESCRIPTION DRUGS.
- Obtained with a non-prescription chemical and dose equivalent (over the counter Drugs).

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Note: Your Prescription Drug benefits are also subject to exclusions. For additional information, refer to the part WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS.

Durable Medical Equipment: including but not limited to:

- Orthopedic shoes or shoe inserts, except as specifically stated in the part WHAT IS COVERED – MEDICAL in the sections “Diabetes Equipment, Education and Supplies” and “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies”
- Air purifiers, air conditioners, humidifiers
- Exercise equipment, treadmills
- Pools and spas
- Elevators
- Supplies for comfort, hygiene or beautification
- Correction appliances or support appliances and supplies such as stockings

Educational Services: Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Agreement. This exclusion does not apply to the Medically Necessary treatment of Pervasive Behavioral Health Treatment for Pervasive Developmental Disorder or Autism, to the extent stated in the part WHAT IS COVERED – MEDICAL in the section “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism.”

Exams: Related to research screenings that are part of a voluntary research program or testing where the screening or exam would be paid for by the research program.

Experimental or Investigational Services: Services or supplies that are Experimental or Investigational. This exclusion applies to services related to Experimental / Investigational services, whether You get them before, during, or after You get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it a Covered Service if it is Experimental / Investigational.

If the Member has a life-threatening or seriously debilitating condition and the requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the part INDEPENDENT MEDICAL REVIEW for further details.

This exclusion does not apply to services covered under “Clinical Trials” in the part WHAT IS COVERED – MEDICAL.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Eyeglasses/Contact Lenses: for Prescription, fitting, or purchase of eyeglasses or contact lenses unless specifically stated as a Covered Service in this Agreement or as required by law. Items and services such as eye surgery or contact lenses to reshape the eye for purposes of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

Eye Surgery: Corrective eye surgery to correct errors of refraction. Surgery includes without limitation nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Foot Care: Coverage is not provided for:

- routine foot care (including the cutting or removal of corns and calluses).
- nail trimming, cutting or debriding.
- hygienic and preventive maintenance foot care.
- cleaning and soaking the feet.
- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

Government Coverage: To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Hair loss or growth treatment: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

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

Hearing Aids: Hearing aids and hearing tests except for as stated in WHAT IS COVERED - MEDICAL. This exclusion does not apply to cochlear implants.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Home Care

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.

Human Growth Hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion, unless Medically Necessary.

Hyperhidrosis: Coverage is not provided for treatment of hyperhidrosis (excessive sweating).

Impotency: Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

Incarceration: Coverage is not provided for care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility testing and treatment: For testing or treatment related to fertilization or Infertility such as diagnostic tests performed to determine the reason for Infertility and any service billed with an Infertility related diagnosis.

Maintenance Therapy or care that is provided when no further gains or improvements in Your current level of function are clear or likely to occur. Maintenance therapy includes care that helps You keep Your current level of function and prevents loss of that function, but does not result in any change for the better.

Missed or Cancelled Appointments.

Non Authorized Travel Related to Expenses: for mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by us or specifically stated as a Covered Service.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

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

However, if You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this Agreement, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered by both Medicare and this Agreement.
- If You receive a service that is covered both by Medicare and this Agreement, our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that You must pay above what is payable by Your Medicare coverage.
- For a particular claim, the combination of Medicare benefits and the benefits we will provide under this Agreement for that claim will not be more than the billed charge for the Covered Service You received.

We will apply any expenses paid by Medicare for Covered Services covered under this Agreement toward Your Deductible, except expenses paid by Medicare Part D.

Non Emergency Care Received in an Emergency Room: Coverage is not provided for care received in an Emergency room that is not Emergency Care, except as specified in this Agreement. This includes, but is not limited to, suture removal in an Emergency room.

Non-Licensed Providers: Treatment or services provided:

- by a non-licensed Provider under the supervision of a licensed Physician, except as stated in the part WHAT IS COVERED – MEDICAL in the section “Behavioral Health Treatment for Pervasive Developmental Disorders or Autism.”
- for which a health care Provider license is not required.

Not Medically Necessary: Any services or supplies which are not Medically Necessary or do not meet our medical policy, clinical coverage guidelines, or benefit policy guidelines. [Definition] [learn more]

WHAT IS NOT COVERED (Exclusions) – MEDICAL

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Nutritional or Dietary Supplements: Nutritional and/or dietary supplements, except as described in this Agreement or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.

Orthodontic Services: This includes dental braces, other orthodontic appliances and any related service unless specifically stated as a Covered Service.

Outdoor Treatment Programs and/or Wilderness Programs.

Over the Counter: Coverage is not provided for Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Agreement or as required by law.

Specimen

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Personal Hygiene, Environmental Control or Convenience Items: Coverage is not provided for personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical Exams: Physical exams to sign up for insurance, as a term of employment, for licensing, or for school activities.

Physician/Other Providers' Charges including:

- Physician or Other Providers' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

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- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Physician stand-by charges.

Private Duty Nursing: Inpatient or outpatient services of a private duty nurse unless provided by a Home Health Care Provider or a Hospice Provider.

Prosthetics: Prosthetics for sports or cosmetic purposes, unless specifically stated as a Covered Service in this Agreement or as required by law. This includes wigs and scalp hair prosthetics.

Providers Services: You get from a non-covered Provider, as defined in this Agreement. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses, physical therapist technicians, and athletic trainers.

Specimen

WHAT IS NOT COVERED (Exclusions) – MEDICAL

Reconstructive Services: except as specifically stated in the part WHAT IS COVERED - MEDICAL, or as required by law.

Regression Prevention: For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

Reversal of Voluntary Sterilization: Reversal of voluntary sterilization or costs associated with the storage of sperm, eggs, embryos and ovarian tissue.

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as specifically stated in the part WHAT IS COVERED - MEDICAL, or as required by law.

Services not approved by the federal Food and Drug Administration: Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Care" and "Urgent Care Services" sections of WHAT IS COVERED - MEDICAL that you receive outside the U.S.
- Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or the other source makes the services available to You or Anthem through an FDA-authorized procedure, except that we do not cover services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol.
- Services covered under "Clinical Trials" in the part WHAT IS COVERED - MEDICAL.

Services or Supplies from Family Members: Services prescribed, ordered, referred by or given by a member of Your immediate family, including Your spouse, Domestic Partner, child, brother, sister, parent, in-law, or self.

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 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,

WHAT IS NOT COVERED (Exclusions) - MEDICAL

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 research.

Shock Wave Treatment: Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

Smoking Cessation Programs: Services to help You quit smoking, treat nicotine dependence or tobacco use. This includes products, Drugs, hypnosis, stop smoking aids, services of smoking cessation clinics, supplies or devices, even if recommended by a Physician. This does not include services with an "A" or "B" rating from the United States **Preventive Services** Task Force (USPSTF) which is explained in WHAT IS COVERED – MEDICAL part, in the section "Preventive Care."

Spinal Decompression Devices: including, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Surrogacy: Services or supplies provided to a person not covered under this Agreement in connection with a surrogate pregnancy including, but not limited to, the bearing of a child by another woman for an infertile couple.

Teeth (Congenital Anomaly): Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Agreement or as required by law.

Teeth, Jawbone, Gums: For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

Telephone/Internet consultations: For telephone consultations or consultations via electronic mail or internet/website, except as required by law, or specifically stated as a Covered Service.

Temporomandibular or Craniomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

Therapy: Coverage is not provided for services, supplies, and equipment for the following:

- Gastric electrical stimulation.
- Hippotherapy.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

Unlisted services: Services not specifically stated in this Agreement as Covered Services unless a covered essential health benefit.

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

Vision care: We will not pay for services incurred for, or in connection with, any of the items below.

- Vision care for Member age 19 and older, unless covered by the medical benefits of this Agreement.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if the Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Agreement.

WHAT IS NOT COVERED (Exclusions) – MEDICAL

- For orthoptics or vision training.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Agreement.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- Oversize lenses.
- For sunglasses.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames purchased outside of our formulary.

Waived Copayment, Coinsurance or Deductible: For any service for which You are responsible under the terms of this Agreement to pay a Copayment, Coinsurance or Deductible and the Copayment, Coinsurance or Deductible is waived by an Out of Network Provider.

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

This exclusion does not apply to Medically Necessary treatments for morbid obesity including bariatric surgery.

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

WHAT IS COVERED – PRESCRIPTION DRUGS

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by us as a first, second, third, or fourth “Tier” Drug. Refer to Your SUMMARY OF BENEFITS to determine Your Copayment, Coinsurance and Deductible (if any) amounts. The determination of Tiers is made by us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. The Tier placement of a Prescription Drug may vary based on the dosage and administration (i.e., by mouth, shots, topical or inhaled) of the Prescription Drug. This may result in the coverage of one form of a Prescription Drug but not another or the other forms of administration of a Prescription Drug in a different Tier. The placement of a particular drug on a given Tier is subject to change.

Note: Your Copayments and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by [REDACTED] designated Pharmacy benefits manager from Drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by [REDACTED] from [REDACTED] designated Pharmacy benefits manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons. Not all forms of a Prescription Drug may be included on the Drug List. The inclusion of a Prescription Drug on the Drug List may vary by the dosage and administration (i.e., mouth, shots,

topical or inhaled) of the Prescription Drug. This may result in the coverage of one dosage or form of a Prescription Drug but not another. The Drug List is subject to change.

If You have a question regarding whether a Drug is on the Prescription Drug List, please call toll free 1-855-3-██████████

Your Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List. To receive Drugs that are not on our Prescription Drug List, see 'Prior Authorization' later in this part. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the Prescription Drug List for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.██████████

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the Pharmacy Benefit Manager's (PBM) Home Delivery Pharmacy;
- Specialty Drugs;
- Self Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self Administered Contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the medical benefits. Please see that section in the part WHAT IS COVERED – MEDICAL under the section "Preventive Care" for more details;

WHAT IS COVERED – PRESCRIPTION DRUGS

- Flu Shots (including administration);
- AIDS vaccine (when approved).
- Appropriate pain management medications for terminally ill patients.

Retail or Home Delivery (Mail Order) Pharmacy

Your Agreement includes benefits for Prescription Drugs You get at a Retail or Home Delivery Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery Pharmacy and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the Prescription from Your Physician and Your Identification Card and they will file Your claim for You. Refer to Your SUMMARY OF BENEFITS for any Copayment, Coinsurance, and/or Deductible that applies when You obtain Prescription Drugs. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Helpful tip: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You in a medical setting (e.g., Physician's office, home care visit, or outpatient Facility) are covered in the part WHAT IS COVERED – MEDICAL. Please read that part for important details.

Maintenance Medication - Home Delivery Pharmacy

If You are taking a Maintenance Medication, You may get the first thirty (30) day supply plus one additional thirty (30) day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must contact the Home Delivery Pharmacy before the second refill and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. If You do not register Your choice each Year through the Home Delivery Pharmacy, You will have to pay the full retail cost of any Maintenance

Customer Service 1-855-████████████████████

Medication. You can tell us Your choice by phone at 1-888-██████████ or by visiting our website at
www.██████████

Your Home Delivery Prescription Drug program is administered by ██████████ PBM which lets You get certain Drugs
by mail if You take them on a regular basis. Your Home Delivery Prescriptions are filled by an independent, licensed
Pharmacy. ██████████ does not dispense Drugs or fill Prescriptions.

Helpful Tip: If You decide to use Home Delivery, we suggest that You order Your refill two weeks before You need it
to avoid running out of Your medication. For any questions concerning the Home Delivery Prescription Drug program,
You can call customer service toll-free at 1-800-██████████

The Prescription must state the dosage and Your name and address; it must be signed by Your Physician.

The first Home Delivery Prescription You submit must include a completed patient profile form. This form will be sent
to You upon becoming eligible for this program. Any subsequent Home Delivery Prescriptions for that Member need
only the Prescription and payment enclosed.

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the
Home Delivery Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary,
injectables, including Self Administered Injectables except Insulin. Please check with the Home Delivery Prescription
Drug program customer service department at 1-800-██████████ for availability of the Drug or medication.

Specialty Pharmacy

Specialty Drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological
products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special
handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing

services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have Your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a thirty (30) day supply per fill. The Specialty Preferred Provider will deliver Your Specialty Drugs to You by mail or common carrier for self administration in Your home. You cannot pick up Your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or Your Physician may order Your Specialty Drug from the Specialty Preferred Program by calling 1-800- [REDACTED]. The Specialty Preferred Provider has dedicated care coordinators to help You take charge of Your health problem and offers toll-free twenty-four (24) hour access to nurses and pharmacists to answer Your questions about Specialty Drugs. A dedicated care coordinator will work with You and Your Physician to get prior authorization. When You call the Specialty Preferred Provider, a dedicated care coordinator will guide You through the process up to and including actual delivery of Your Specialty Drug to You. When You order Your Specialty Drug by telephone, You will need to use a credit or debit card to pay for it. You may also submit Your Specialty Drug Prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Coinsurance as found in the SUMMARY OF BENEFITS. When You order Your Specialty Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

Customer Service 1-855-████████████████████

You or Your Physician may obtain a list of Specialty Drugs available through the Specialty Preferred Provider by contacting Member Services by calling toll free 1-800-██████████ or online at www.██████████ You or Your Physician may also obtain order forms by contacting Member Services or by accessing our website at www.██████████

Attn: ██████████ Specialty Pharmacy Program

2825 Perimeter Road

Mail Stop – INRX01 A700

Indianapolis, IN 46241

Phone: 1-800-██████████

Fax: 1-800-██████████

How to obtain an exception to the Specialty Pharmacy Program

If You believe that You should not be required to get Your Specialty Drug through the Specialty Pharmacy Program, You or Your Physician must complete an exception to the Specialty Pharmacy Program form to request an exception and send it to us. The form can be mailed or faxed to us. If You need a copy of the form, You may call us at 1-800-██████████ to request one. You can also get the form online at www.██████████ If we have given You an exception, it will be in writing for the approved amount of time as medically appropriate. If You believe that You still should not be required to get Your medication through the Specialty Pharmacy Program, when Your prior exception approval expires, You must again request an exception. If we deny Your request for an exception, it will be in writing and will tell You why we did not approve the exception.

Urgent or Emergency Need of a Specialty Drug subject to the Specialty Pharmacy Program

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

WHAT IS COVERED – PRESCRIPTION DRUGS

If You order Your Specialty Drug through the Specialty Preferred Provider and it does not arrive, if Your Physician decides that it is Medically Necessary for You to have the Drug immediately, we will authorize an override of the Specialty Pharmacy Program requirement for a thirty (30) day supply or less to allow You to get an Emergency supply of medication from an In Network Pharmacy near You. A customer service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Coinsurance/Copayment.

Important Details about Prescription Drug Coverage

Your Prescription Drug coverage 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 give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In Network Pharmacist will be told of any rules when You fill a Prescription, and will be also told about any details we need to decide benefits.

Drug Utilization Review

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

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact Your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both You and Your Provider.

You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for You. However, if we determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, 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.)

If prior authorization is denied You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES.

For a list of Drugs that need prior authorization, please call 1-855- [REDACTED] or visit [www.\[REDACTED\]](http://www.[REDACTED]) The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or Generic Drugs are covered under the Prescription Drug coverage.

Step Therapy

Step therapy is a process in which You may need to use one type of drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a Physician decides that a certain Prescription Drug is needed, the prior authorization will apply.

Administered by a Medical Provider

Your Agreement also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an outpatient Facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self Administered Injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Retail or Home Delivery Pharmacy" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Retail or Home Delivery Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Retail or Home Delivery Pharmacy" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the SUMMARY OF BENEFITS. In most cases, You must use a certain amount of Your Prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets You pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets You get a thirty (30) day supply (fifteen (15) tablets) of the higher strength Drug when the Physician tells You to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and You should talk to Your Physician about the choice when it is available. To get a list of the Drugs in the program call 1-855-██████████

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, we may allow access to network rates for Drugs not listed on our Formulary.

Customer Service 1-855- [REDACTED] or www. [REDACTED]

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Claims and Member Service

For information and assistance, the Member may call customer service at 1-855- [REDACTED] or write us at:

[REDACTED]

[REDACTED] Prescription Drug Program

P.O. Box 4165

Woodland Hills, CA 91365-4165

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of California – 1-866- [REDACTED]

Pharmacy Benefits administered by [REDACTED] Rx Network – 1-800- [REDACTED]

WHAT IS COVERED – PRESCRIPTION DRUGS

WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS

In addition to the exclusions in WHAT IS COVERED – PRESCRIPTION DRUGS, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager (PBM).

Clinically-equivalent alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

Compound Drugs: Compounded products unless the Drug is listed on our Drug Formulary or one of the ingredients requires a Prescription by law.

Contrary to approved medical and professional standards: Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.

Delivery charges: Charges for delivery of Prescription Drugs.

Drugs given at the Provider's office or Facility: Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a Physician. This exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the part WHAT IS COVERED – MEDICAL in the "Therapy Services" section or Drugs covered under the "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" benefit are Covered Services.

Drugs that do not need a Prescription: Drugs that do not need a Prescription by federal law (including Drugs that need a Prescription by State law, but not by federal law), except for injectable insulin.

Drugs over quantity or age limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by us.

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Drugs over the quantity prescribed or refills after one (1) Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.

Items covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.

Items covered as medical supplies: Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where You get the service or item. Over the counter Drugs, devices or products, are not Covered Services.

An allergenic extract or vaccine.

Lost or stolen Drugs: Refills of lost or stolen Drugs.

Mail service programs other than the PBM's Home Delivery program: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery program, unless we must cover them by law.

Non-approved Drugs: Drugs not approved by the FDA.

Off label use: Off label use, unless we must cover the use by law or if we approve it. Drug must be Medically Necessary and recognized for treatment of off label condition by compendia or major peer reviewed medical journal as defined by Anthem.

Over the counter items: Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Drugs when any version or strength becomes available over the counter.

Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

Weight loss Drugs: Any Drug mainly used for weight loss.

Drugs used for cosmetic purposes.

Prescription Drugs used to treat infertility.

WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS

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GETTING APPROVAL FOR BENEFITS

Your Agreement includes the processes of **Precertification**, predetermination and post service clinical claims review to decide when services are **Medically Necessary**. Covered Services must be Medically Necessary for benefits to be covered.

Certain services require Precertification in order for benefits to be provided. In Network Providers will initiate the review on Your behalf. An Out of Network 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 Precertification. You may also call us directly. Precertification criteria are based on multiple sources including medical policy, clinical guidelines, and Pharmacy and therapeutics guidelines. 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.

Whenever Precertification has not been performed for the following services received from an Out of Network 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 treatment for Mental Health and Substance Abuse Services, Skilled Nursing Facility, Infusion Therapy (in any setting) or Home Health Care.

This Copayment is in addition to any other Copayment required by this Agreement. It will NOT apply toward satisfying Your Yearly Deductible and it will continue to be required even after the Yearly Out of Network Out of Pocket Maximum has been reached. This Copayment is not required in Emergencies.

If You have any questions about the information in this part, You may call customer service at 1-855- [REDACTED]

GETTING APPROVAL FOR BENEFITS

Types of Requests

Precertification

A required review of a service, treatment or admission for a Medical Necessity determination which must be done before the service, treatment or admission start date. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer, Precertification is not needed. Services for which Precertification 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 Facility admissions (except inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer);
- Inpatient and Outpatient Facility treatment for Mental Health and Substance Abuse Services;
- Skilled Nursing Facility stays;
- Center of Medical Excellence (CME) procedures (see CME requirements in the part WHAT IS COVERED – MEDICAL);
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or Your home or other residential setting;
- Home Care Services;
- Specific outpatient services, including diagnostic treatment and other services;
- Specific surgical procedures, wherever performed, as specified by us;
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed, such as:
 - Computerized Tomography (CT)
 - Computerized Tomography Angiography (CTA)
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Magnetic Resonance Spectroscopy (MRS)
 - Nuclear Cardiology (NC)

GETTING APPROVAL FOR BENEFITS

- Positron Emission Tomography (PET)
- PET and PET/CT Fusion
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Echocardiogram
- Specific medical supplies and equipment;
- Ambulance in a non-Emergency;
- Behavioral health treatment for Pervasive Developmental Disorder or autism;
- Physical and Occupational Therapy;
- Speech Therapy; and
- Other services wherever they are rendered.

For a list of current procedures requiring Precertification, please call customer service at 1-855- [REDACTED]

Predetermination

An optional, voluntary Prospective or Continued Stay Review request for a Medical Necessity determination for a service or treatment.

Post Service Clinical Claims Review

A Retrospective review for a determination to decide the Medical Necessity or Experimental/Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Physician will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

GETTING APPROVAL FOR BENEFITS

Revoking or modifying a Precertification Review decision

Anthem 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 Agreement ends;
- You reach a Benefit Maximum that applies to the service in question;
- Your benefits under the Agreement change so that the service is no longer covered or is covered in a different way.

Who is responsible for Precertification	
Services given by an In Network Provider	Services given by an Out of Network Provider
Provider	<ul style="list-style-type: none"> • The Member must get precertification. • If the Member fails to get precertification, the Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.

We use our clinical coverage guidelines, such as medical policy clinical guidelines, preventive care clinical coverage guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. **Your Agreement takes precedence over these guidelines.**

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if such change furthers the provision of cost effective, value based and/or quality services.

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We may also select certain qualifying Providers to take part 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 [REDACTED] exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that [REDACTED] will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line Precertification list or contacting the customer service at 1-855- [REDACTED]

Request Categories

- Urgent – A request for Precertification or Predetermination that is conducted while You are receiving treatment for a medical condition that in the view of the treating Provider or any Physician with knowledge of Your medical condition, could without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.
- Prospective – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- Continued Stay Review – A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- Retrospective – A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for Medical Necessity according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, we will

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follow State laws. If You live in and/or get services in a state other than the State where Your Agreement was issued other state-specific requirements may apply. You may call customer service at 1-855- [REDACTED] for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	Seventy-two (72) hours from the receipt of all information reasonably necessary and requested, or Seventy-two (72) hours from the receipt of request
Prospective non-Urgent	Five (5) business days from the receipt of all information reasonably necessary and requested
Continued Stay Review when hospitalized at the time of the request	Seventy-two (72) hours from the receipt of all information reasonably necessary and requested, or Seventy-two (72) hours from the receipt of the request and prior to expiration of current certification
Continued Stay Review Urgent when request is received more than twenty-four (24) hours before the end of the previous Authorization	Twenty-four (24) hours from the receipt of the request
Continued Stay Review Urgent when request is received less than twenty-four (24) hours before the end of the previous Authorization or no previous Authorization exists	Seventy-two (72) hours from the receipt of the request
Continued Stay Review non-Urgent	Five (5) business days from the receipt of all information reasonably necessary and requested
Retrospective	Thirty (30) days from the receipt of all information reasonably necessary and requested, or Thirty (30) calendar days from the receipt of the request

If more information is needed to make our decision, we will follow State and federal law and tell the requesting Provider and send written notice to You or Your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by State and federal law. Notice may be given by the following methods:

- Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.
- Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

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Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date You get service:

- You must be eligible for benefits;
- The service or supply must be a covered benefit under Your Agreement;
- The service cannot be subject to an Exclusion under Your Agreement; and
- You must not have exceeded any applicable limits under Your Agreement.

For a copy of the Medical Necessity Review Process, please contact customer service at 1-855- [REDACTED]

If You disagree with a determination by us, You have the right to file a Grievance as outlined in the part COMPLAINTS AND GRIEVANCES and a request for Independent Medical review as outlined in the part INDEPENDENT MEDICAL REVIEW.

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to You.

If You meet program criteria and agree to take part, we will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your chosen representative, treating Physician(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service through our Case Management program. We may also extend Covered Services beyond the

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Benefit Maximums of this Agreement. We will make our decision case-by-case, if the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify You or Your representative in writing.

Specimen

GETTING APPROVAL FOR BENEFITS

ALTERNATIVE BENEFITS

In order for You to obtain medically appropriate care in a more economical and cost effective way, we may recommend an alternative treatment plan. This may include providing benefits not otherwise covered under this Agreement. A **personal case manager** will review the medical records and discuss Your treatment with the attending Physician, You and Your family.

We make treatment suggestions only. Any decision regarding treatment belongs to You and Your Physician.

Benefits are provided for such an alternative treatment plan only on a case-by-case basis. We have absolute discretion in deciding whether or not to offer substitute benefits, which alternative benefits may be offered, and the terms of the offer. Our substitution of benefits in a particular case in no way prevents us from strictly applying this Agreement's benefits, limitations and exclusions at any other time or for any other Member.

Alternative benefits are considered only when all of the following criteria are satisfied:

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

[REDACTED] will determine appropriate cost sharing (Deductible, Copayments, and Coinsurance) if alternative benefits are provided. This includes alternative benefits accumulating toward Benefit Maximums of this Agreement.

Note: We reserve the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

ALTERNATIVE BENEFITS

CONTINUED BENEFITS

If, on the date we cancel Your coverage by written notice (except for cancellation due to misrepresentation or fraudulent statements, ceasing coverage in the individual market or cancellation due to withdrawal of the health benefit plan from the individual health care market as stated in the part YOUR ELIGIBILITY), You are suffering from either an injury sustained or an illness arising while Your coverage under this Agreement was in effect, benefits will continue, but limited by and subject to all of the following:

1. These continued benefits cover only treatment of an injury sustained or an illness arising while Your coverage under this Agreement was in effect. When we refer to an injury sustained while Your coverage under this Agreement was in effect, we mean that the incident or accident directly causing the injury must have occurred while Your coverage under this Agreement was in effect. When we refer to an illness arising while Your coverage under this Agreement was in effect, we mean that either the illness was first diagnosed while Your coverage under this Agreement was in effect or Your illness first manifested itself by signs or symptoms by which a Physician could have diagnosed the illness while Your coverage under this Agreement was in effect.
2. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of Your coverage under this Agreement. If You are in a Hospital or Skilled Nursing Facility on the last day of that ninety (90) day period for treatment of a condition covered under these continued benefits, benefits will continue until the first of the following occurs:
 - (i) the date of discharge from the Hospital or Skilled Nursing Facility, or
 - (ii) care or treatment is no longer Medically Necessary.

Note: All conditions, reductions, limitations and exclusions of this Agreement, including any Benefit Maximums, will apply to these continued benefits. In no event will benefits in excess of any maximum benefits be provided.

For information about continuation of care when an agreement terminates between an In Network Provider and us, see the part IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions).

CONTINUED BENEFITS

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DUPLICATION OF ANTHEM BENEFITS

If, while covered under this Agreement, You are also covered by another Anthem Individual Agreement:

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

Specimen

DUPLICATION OF ANTHEM BENEFITS

THIRD PARTY LIABILITY

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

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

THIRD PARTY LIABILITY

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

Below is important information regarding this Agreement.

Benefits not transferable: You are the only person entitled to receive benefits under this Agreement.

FRAUDULENT USE OF SUCH BENEFITS CAN RESULT IN CANCELLATION OF THIS AGREEMENT AND APPROPRIATE LEGAL ACTION MAY BE TAKEN.

Changes in Premium: The Premium for this Agreement may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in our records sixty (60) days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Content of the Agreement: This Agreement, including any endorsements or attached paper, is the entire contract of insurance. Its terms can only be changed by a written endorsement signed by one of our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS AGREEMENT. [That's why this is a specimen and the Insurer's name is redacted]

Continuation of care after termination of a Provider: Subject to the terms and conditions set forth below, we will pay benefits at the In Network Provider level for Covered Services (subject to applicable Deductibles, Copayment and Coinsurance and other terms) rendered by a Provider whose participation we have terminated from our network.

- The Member must be under the care of the In Network Provider at the time of our termination of the Provider's participation in our network. The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with us prior to termination from our network. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination from our network. 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.
- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.

We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:

- An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by us in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
- The care of a Newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Provider's contract termination date.

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact customer service at 1-855- [REDACTED]. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Agreement. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiate

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the terminated Provider does not agree to the same reimbursement and/or contractual requirements, we are not required to continue that Provider's services. If You disagree with our determination regarding continuation of care, please refer to the part INDEPENDENT MEDICAL REVIEW.

How to file medical claims: When using an In Network Provider they will bill Anthem directly for services rendered to You. In order for the Provider to submit a claim on Your behalf, You must give the Provider information necessary for the claim to be filed, such as Your Anthem ID card.

For Out of Network Providers, the Provider may or may not bill Anthem for services rendered to You. If an Out of Network Provider does not submit a claim to Anthem, in order for the claim to be considered for reimbursement, You must submit a claim to us by completing the member claim form and attaching support documentation from the Provider, including an itemized bill. The member claim form can be found online at www.anthem.com/ca or requested by calling customer service at 1-855-383-7247.

All information on the member claim form and itemized bill must be complete and legible. If the member claim form is not legible or is missing information, the form will be returned to You for any missing, incomplete or illegible information. The information on the itemized bill will be used to determine benefits so it must support the information on the member claim form. The member claim form contains more detailed instructions on how to complete the form and what information is needed.

If You are filing a member claim form for more than one Out of Network Provider, a separate member claim form is required for each Provider. If You are filing a member claim form for more than one Member, a separate member claim form is required for each Member.

When You receive health care outside of the United States, You will need to submit an itemized bill and medical records for services rendered. The itemized bill and medical records must be translated into English and include the billed charges.

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

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How to send a member claim form: Prior to submitting Your member claim form and itemized bill, You should make copies of the documents for Your own records and attach the original bills to the completed member claim form. The bills and the member claim form should be mailed to:

[REDACTED]
P.O. Box 60007

Los Angeles, CA 90060-0007

Laws governing the Agreement: This Agreement is subject to the laws of the State of California. Any provision of this Agreement which, on its Effective Date, is in conflict with any law is amended to conform to the minimum requirements of such law.

Legal Actions: No action at law or at equity may be brought to recover this Agreement sooner than sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. 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.

Liability of Subscriber to Pay Providers: In accordance with Anthem's In Network Provider agreements, Members will not be required to pay any In Network Provider for amounts owed to that Provider by Anthem (other than Copayments/Coinsurance), even in the unlikely event that Anthem fails to pay the Provider. Members are liable, however, to pay Out of Network Providers for any amounts not paid to those Providers by Anthem.

Note: for Emergency Care rendered within California by an Out of Network Provider, other than an ambulance Provider, You will not be responsible for any amount in excess of the Reasonable and Customary Value. However, You are responsible for any charges in excess of the Reasonable and Customary Value that may be billed by an Out of Network ambulance Provider.

Not an Annual Agreement: THIS IS NOT AN ANNUAL AGREEMENT. The Plan Period is monthly and defines the period of Your coverage but does not affect and is not affected by any provisions defining Your Deductible or other cost-sharing obligations which are calculated on a Yearly basis. Your Agreement expires at the end of each monthly Plan Period but will automatically renew upon timely payment by the Monthly Premiums Due Date of the Premium for the next monthly Plan Period, unless we have exercised our right to terminate, cancel or non-renew as described in this Agreement. Premiums, benefits, terms, Deductibles, Out of Pocket Maximums and conditions may be modified effective at any renewal date following sixty (60) days written notice to You, and such changes may be implemented at any time during the next Anthem Blue Cross Period following renewal.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

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Notice: We will meet any notice requirements by mailing the notice to You at the address listed in our records. You will meet any notice requirements by mailing the notice to:

████████████████████
P.O. Box ██████
Oxnard, California 93031-9051

Payment to Providers and Provider reimbursement: Benefits for In Network Providers are based on the Maximum Allowed Amount. In Network Providers have an agreement in effect with us and have agreed to accept the Maximum Allowed Amount as payment in full. You will not be required to pay any In Network Provider for amounts owed to that Provider by us (excluding Deductible, Copayments/Coinsurance, and services or supplies that are not a covered benefit of the Plan), even in the unlikely event that we fail to pay the Provider.

Out of Network Providers do not have an agreement with Anthem. Your personal financial costs when using Out of Network Providers may be considerably higher than when You use In Network Providers. You will be responsible for any balance of a Provider's bill which is above the Maximum Allowed Amount payable under this Plan for Out of Network Providers. You should read the SUMMARY OF BENEFITS and the part WHAT IS COVERED – MEDICAL carefully to determine those differences. We pay the benefits of this Plan directly to In Network Hospitals, In Network Physicians, medical transportation Providers, certified nurse midwives, registered nurse practitioners and other In Network Providers, whether You have authorized assignment of benefits or not. If You receive non-Emergency Services from an Out of Network Provider, we have the right to make payment directly to You and You will be responsible for payment to that Provider. Any assignment of benefits, even if assignment includes the Provider's right to receive payment, will not be effective unless an Authorized Referral has been approved by us. In all cases, we will pay Providers directly when Emergency Services and care are provided to You. We will continue such direct payment until the Emergency Care results in stabilization.

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

Receipt of information: By submitting an application for coverage, You have authorized every Provider who has furnished or is furnishing care to disclose all facts, opinions or other information pertaining to Your care, treatment and physical conditions, upon our request. We are also entitled to receive from any Provider of service information about You that is necessary to administer claims on Your behalf according to federal/State law. This right is subject to all applicable **confidentiality requirements**. You agree to assist in obtaining this information if needed. Failure to

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

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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 by us.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact us at 1-855- [REDACTED] for a copy of our policies and procedures for preserving Your medical record confidentiality.

Relationship of Parties: Providers are independent contractors. [REDACTED] is not responsible for any claim for damages or injuries suffered by the Member while receiving care from any Provider.

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

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

Terms of coverage:

- In order for You to be entitled to benefits under this Agreement on a specific date, Your coverage under this Agreement must be in effect on the date You received services or supplies except as specifically stated in the parts CONTINUED BENEFITS and IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions), continuation of care after termination of a Provider.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by us as provided in the parts RIGHT TO MODIFY OR CHANGE THE AGREEMENT.
- The benefits to which You may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date You receive the service or supply.

Time limit on certain defenses: After You have been insured under this Agreement for two (2) consecutive Years we will not use any misstatements You may have made in Your application for this Agreement to either void this Agreement or to deny a claim for any Covered Services incurred after the expiration of such two (2) Year period.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

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Time of payment of claim: Any benefits determined to be due under this Agreement shall be paid in a timely manner after we receive a claim together with any such additional information reasonably necessary to determine our obligation under this Agreement.

Workers' compensation insurance: This Agreement does not take the place of or affect any requirement for or coverage by workers' compensation insurance. Additionally, as stated in the part WHAT IS NOT COVERED (Exclusions) - MEDICAL, this Agreement does not cover any condition for which benefits are recovered or can be recovered either by any workers' compensation law or similar law even if You do not make a claim for those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation law or similar law, we will provide the benefits of this Agreement 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.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

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COMPLAINTS AND GRIEVANCES

Learn More at www.HeathReformQuotes.com

"Grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

If You have a question about Your eligibility, Your benefits under this Agreement, or concerning a claim, please call customer service at 1-855-383-7247, or You may write to us. Please address Your correspondence to:

[REDACTED]
Attn: Customer Service Department
P.O. Box [REDACTED]
Oxnard, CA 93031-9051

Our customer service staff will answer Your questions or assist You in resolving Your issue.

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

All grievances received by us will be acknowledged in writing within five (5) days. We will send you a confirmation letter within five (5) days after we receive Your grievance. After we have reviewed Your grievance, we will send You a written statement on its resolution or pending status. If Your case involves an imminent and serious threat to Your health including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, You have the right to request an expedited review of an appeal. Expedited appeals must be resolved within three (3) days.

If You are dissatisfied with the resolution of Your grievance, or if Your grievance has not been resolved after at least thirty (30) days, You may submit Your grievance to the Department of Managed Health Care. For review prior to

COMPLAINTS AND GRIEVANCES

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binding arbitration see the section "Department of Managed Health Care." If Your case involves an imminent and serious threat to Your health, as described above, You are not required to complete our grievance process, but may immediately submit Your grievance to the Department of Managed Health Care for review.

You may at any time pursue Your ultimate remedy, which is Binding Arbitration. See the parts INDEPENDENT MEDICAL REVIEW, BINDING ARBITRATION, and IMPORTANT INFORMATION ABOUT YOUR PLAN.

Specimen

COMPLAINTS AND GRIEVANCES

Customer Service 1-855- [REDACTED]

Learn more at www.HealthReformQuotes.com

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INDEPENDENT MEDICAL REVIEW

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

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

- The Member has a life-threatening or seriously debilitating condition
 - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
 - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The Member's Physician certifies that the Member has a life-threatening or seriously debilitating condition which:
 - Standard therapies have not been effective in improving the condition of the Member, or
 - Standard therapies would not be medically appropriate for the Member, or
 - There is no more beneficial standard therapy covered by the plan than the therapy proposed, and
 - Who has provided the supporting evidence.
- The proposed treatment must be recommended by the Member, an In Network Physician, or a board certified or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that the **proposed treatment is likely to be more beneficial to the Member than available standard therapy.**
- If independent medical review is requested by the Member or by a qualified Out of Network Physician, as described above, the requester must supply two (2) items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review (and within 24 hours of approval of the request for review involving an imminent and serious threat to the health of the Member), we will provide the independent medical

INDEPENDENT MEDICAL REVIEW

review organization designated by the Department with: A copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member's Physician. Additionally, any newly developed or discovered relevant medical records identified by us or our In Network Providers after the initial documents are provided will immediately be forwarded to the independent medical review organization.

- The independent medical review organization will render its determination within thirty (30) days of the request (if the Member's Physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within seven (7) days of the request for expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

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

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

INDEPENDENT MEDICAL REVIEW

Independent Medical Review of Grievances involving a Disputed Health Care Service

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

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

Eligibility

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

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

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

INDEPENDENT MEDICAL REVIEW

Your case. If the IMR determines the service is Medically Necessary, we will provide benefits for the health care service.

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

For more information regarding the IMR process, or to request an application form, please call our customer service department toll free at 1-800-365-0609.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at 1-800-365-0609 and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than thirty (30) days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for Emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site <http://www.hmoHELP.ca.gov> has complaint forms, IMR application forms and instructions online.

INDEPENDENT MEDICAL REVIEW

BINDING ARBITRATION

ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT 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 or any other issues related to the Plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are **giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.** YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND MEDICAL MALPRACTICE CLAIMS.

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

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

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

BINDING ARBITRATION

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parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless You and 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.

Please send all Binding Arbitration demands in writing to:

[REDACTED]

P.O. Box [REDACTED]

Oxnard, CA 93031-9086

Specimen

BINDING ARBITRATION



Listed below are the **definitions** that contain the meaning of key terms used in this Agreement. Throughout the Agreement, the terms printed in bold face below will appear with the first letter of each word in capital letters.

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

Adopted Child and Adoptive Child: A child whose birth parent or appropriate legal authority has signed a written document granting the Subscriber, enrolled Spouse or enrolled Domestic Partner the right to control health care for or, absent this document, other evidence exists of this right.

Agreement means this Anthem Individual PPO Evidence of Coverage issued to You by Anthem.

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

Ancillary Provider means an independent clinical laboratory, durable/home medical equipment, and/or Specialty Pharmacy.

[REDACTED] means **[REDACTED]** California, doing business as **[REDACTED]** a health care service plan regulated by the Department of Managed Health Care. In this Agreement, the words "we," "us," "our," and "**[REDACTED]**" refer to **[REDACTED]**

Authorized Referral occurs when a Member, because of his or her medical needs, requires the services of a specialist who is an Out of Network Physician, or requires special services or Facilities not available at a Contracting Hospital, but only when the Referral has been authorized by Anthem *before* services are rendered and when the following conditions are met:

1. there is no In Network Physician who practices in the appropriate specialty or there is no Contracting Hospital which provides the required services or has the necessary Facilities,
2. that meet the adequacy and accessibility requirements of State or federal law and

DEFINITIONS

3. the Member is referred to Hospital or Physician that does not have an agreement with Anthem for a Covered Service by an Anthem In Network Physician.

If there is a shortage of one or more types of Providers to ensure timely access to Covered Services, Anthem will also assist covered individuals to locate available and accessible contract Providers in neighboring Service Areas for obtaining health care services in a timely manner appropriate to the Member's health needs.

For additional information on how to obtain an Authorized Referral, see the part HOW YOUR COVERAGE WORKS.

Authorized Service(s): A Covered Service You get from an Out of Network Provider that we have agreed to cover at the In Network level. Such service may be authorized because an In Network Provider is not located:

1. within a thirty (30) mile radius of the principal residential address that we have on file, or
2. within the county in which the principal residence is located, whichever is less.

You will have to pay any In Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. Please see Your SUMMARY OF BENEFITS and the part CLAIMS AND PAYMENTS for more details.

Benefit Maximum. The most we will cover for a Covered Service during a Benefit Period.

Benefit Period means a calendar Year (January 1 through December 31) for which a health benefit plan provides coverage for health benefits.

Brand Name Drug (Brand Drug): Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance is Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service as stated in the SUMMARY OF BENEFITS. You pay Coinsurance **after any Deductible** You owe. For example, if the Agreement's allowed amount for an Office Visit is \$100 and You have met Your Deductible, Your Coinsurance payment of 20% would be \$20. Your Coinsurance does not apply to charges for services which are not covered or charges in excess of the amount we will allow for payment and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

DEFINITIONS

Contracting Hospital is a Hospital which has a contract with us to provide care to our Members. A Contracting Hospital is not necessarily a Preferred In Network or In Network Hospital. To determine whether a Hospital contracts with Anthem, You may contact us at 1-855-383-7247 or check www.anthem.com/ca.

Copayment is the fixed amount (for example \$15) due and payable by the Member to the Provider for a covered health care service as stated in the SUMMARY OF BENEFITS, usually when You receive the service. The amount can vary by the type of covered health care service.

Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Note: Cosmetic Surgery does not become Reconstructive Surgery because of psychological or psychiatric reasons except in cases where it is for gender reassignment surgery.

Cost-Share: The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services are health care services that are Medically Necessary services, Drugs, or supplies for which You are entitled to receive benefits and that are listed in the parts WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS.

Custodial Care is care provided primarily to meet Your personal needs that does not require the regular services of trained medical or Health Professionals, including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self administered.

Deductible: The term Deductible means the amount of charges You may have to pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Agreement. Your Deductible is stated in Your SUMMARY OF BENEFITS. The Prescription Drug Deductible may be separate from the Medical Deductible and may or may not accumulate towards satisfying the Medical In Network or Out of Network Provider Deductibles. Additional information is available in the parts CLAIMS AND PAYMENTS and WHAT IS COVERED – PRESCRIPTION DRUGS.

Dental Services are diagnostic, preventive or corrective procedures to on, or to, the teeth or gums, no matter why the services are provided and whether in treatment of a medical, dental or any other type of condition.

DEFINITIONS

Dependents are members of the Subscriber's family who are eligible and accepted under this Agreement as stated in the part YOUR ELIGIBILITY.

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

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

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

Domestic Partner or 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 eligibility requirements for Domestic Partners outlined under the part YOUR ELIGIBILITY.

DEFINITIONS

Drugs means Prescription Drugs approved by the State of California or the federal Food and Drug Administration (FDA) for general use by the public. Insulin is considered a Prescription Drug.

Effective Date is the date on which Your coverage under this Agreement begins.

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

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

Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
2. Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment to Stabilize the patient.
3. Being in active labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

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

Facility includes, but not limited to, a Hospital, Ambulatory Surgical Center, Mental Health / Substance Abuse Facility, or Skilled Nursing Facility, as defined in this Agreement and other Facilities approved by us. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Family Plan means a Plan in which the Subscriber is enrolled with one or more Dependents. For additional information on Newborns during the first sixty (60) days from birth and Adopted Children during first sixty (60) days

DEFINITIONS

from the date the Subscriber, enrolled spouse, or enrolled Domestic Partner is granted the right to control health care for an Adopted Child, refer to the part YOUR ELIGIBILITY.

Formulary is a list which we have developed of outpatient Prescription Drugs which may be cost-effective, therapeutic choices. Any In Network Pharmacy can assist You in purchasing Drugs listed on the Formulary. You may also get information about covered Formulary Drugs by calling 1-800-██████████ (or TTY/TDD 1-800-905-9821).

Generic Drugs (Generic): Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance means a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where the plan is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

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

Hospice Care is a coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available twenty-four (24) hours a day, seven (7) days a week. The Hospice must meet the licensing requirements of the State or locality in which it operates.

Hospital is a health Facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and it must be licensed to provide general acute inpatient and outpatient services 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.

DEFINITIONS

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

- licensed by the California Department of Health Services,
- qualified to provide short-term inpatient treatment according to State law,
- accredited by the Joint Commission on Accreditation of Healthcare Organizations,
- staffed by an organized medical and professional staff which includes a Physician as medical director, and
- actually providing an acute level of care.

Individual Plan means this Plan when only the Subscriber is enrolled.

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

Infusion Therapy is the administration of Drugs or 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 Plan, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In Network Pharmacy is a Pharmacy that has an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered.

In Network Provider is a Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Member through negotiated payment arrangements under this Plan.

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

Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a

DEFINITIONS

Customer Service 1-855-383-7247 or www.anthem.com/ca

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Maintenance Medication, please call customer service at 1-855-383-7247 or check our website at www.anthem.com for more details.

Maximum Allowed Amount for this Plan is the maximum amount of reimbursement we will allow for Covered Services and supplies. See the section 'Maximum Allowed Amount' in the part HOW YOUR COVERAGE WORKS.

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

- permanently placing the Member'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 and Medical Necessity services are procedures, treatments, supplies, devices, equipment, Facilities or Drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to an Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. In evaluating new technology and whether to consider it as eligible for coverage under our Agreement, we consider peer-reviewed medical literature, consultations with Physicians, Specialists and other health care professionals, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

DEFINITIONS

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

Mental and Nervous Disorders that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental and 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. Mental and Nervous Disorders include any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV). **Some Mental and 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** (also known as Chemical Dependency); depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Mental or Nervous Disorders include Severe Mental Illness and Serious Emotional Disturbances of a Child and any condition meeting this definition is a Mental and Nervous Disorder no matter what the cause. 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.

Minimum Essential Coverage: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

Monthly Premium Due Date is the first day of the Agreement Period for which the Premium is paid.

Negotiated Price applies only to out of state and, in cases of Medical Emergency some foreign country Providers. This often consists of a simple discount which reflects the actual price paid by the on-site Blue Cross/Blue Shield Licensee/Plan. However, sometimes it is an estimated price that factors into the actual price expected, settlements, withholds, any other contingent payment arrangements and non-claims transactions with Your health care Provider or specified group of Providers. The Negotiated Price may also be billed charges reduced to reflect an average expected savings with Your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

DEFINITIONS

The Negotiated Price will also be adjusted in the future to correct for over -or underestimation of past prices. However, the amount You pay is considered a final price.

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

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

- History-Gathering of information on an illness or injury.
- Examination
- Physician's medical decision regarding the 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 services performed other than the three services specifically listed above.

Other Eligible Providers do not enter into agreements with us. These Providers include:

- blood bank,
- dentist (D.D.S.),
- dispensing optician,
- respiratory therapist.

Out of Network Pharmacy is a Pharmacy that does not have an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out of Network Pharmacy.

Out of Network Provider is a Provider that does *not* have an agreement or contract with us, or our subcontractor(s) to give services to our Member through negotiated payment arrangements under this Plan. You will often get a lower level of benefits when You use Out of Network Providers.

Pharmacy means a licensed retail or home delivery Pharmacy.

Pharmacy Benefits Manager (PBM) is a Pharmacy benefits management company with which Anthem contracts to manage Pharmacy benefits. Anthem's Pharmacy Benefits Manager has a nationwide network of retail Pharmacies, a mail service Pharmacy, and clinical services that include Formulary management.

DEFINITIONS

The management and other services the Pharmacy Benefits Manager provides include, but are not limited to: managing a network of retail Pharmacies and operating a mail service Pharmacy. Anthem's Pharmacy Benefits Manager, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

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

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided or
- One of the following Providers, but only when the Provider is
 - licensed to practice where the care is provided,
 - rendering a service within the scope of that license and such license is required to render the service, and
 - providing a service for which benefits are specified in this Plan:
 - Dentist (D.D.S.)
 - Optometrist (O.D.)
 - Dispensing optician
 - Podiatrist or chiropractist (D.P.M. or D.S.C.)
 - Clinical psychologist
 - Certified registered nurse anesthetist (C.R.N.A.)
 - Clinical social worker (C.S.W. or L.C.S.W.)
 - Marriage, family and child therapist (M.F.C.T.)
 - Physical therapist (P.T. or R.P.T.)*
 - Speech pathologist*
 - Speech therapist*
 - Audiologist*
 - Occupational therapist (O.T.R.)*
 - Respiratory therapist*
 - Registered nurse practitioner (R.N.P.)*
 - Certified nurse midwife

DEFINITIONS

- Psychiatric Mental Health Nurse*
- Acupuncturist

Note: The Providers indicated by an asterisk (*) are covered only by referral.

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

Premium is the monthly charge You must pay Anthem to establish and maintain coverage under this Agreement. Premium may also be referred to as Subscription Charge.

Premium Payment(s) means monthly Premium received by Anthem that has been approved by Your financial institution. If funds are not approved by Your financial institution, they are not considered received and this Agreement may be cancelled for non-payment of Premium. Refer to "When Coverage Ends" in the part YOUR ELIGIBILITY for additional information about cancellation when You do not pay Premiums.

Prescription means a written order issued by a Physician.

Prescription Drug means Drug.

Prescription Drug Maximum Allowed Amount is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem using cost information provided to by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change.

Primary Care Physician (PCP) is a Physician who gives or directs health care services for You. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Provider is a professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give You services that State law says we must cover. Covered Providers are described throughout this Agreement. If You have a question about a Provider not described in this Agreement please call customer service at 1-855-383-7247.

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

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

DEFINITIONS

Reasonable and Customary Value

1. For professional Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered;
2. For Facility Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on each Provider's cost-to-charge ratio as reported by the Provider to a California governmental agency and the actual claim submitted to us.

Reconstructive Surgery is surgery that is Medically Necessary and appropriate and is performed to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to the extent possible.

Benefits include Reconstructive Surgery to correct deformities caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve bodily function or to create a normal appearance, to extent possible. Benefits include surgery performed to restore symmetry after a mastectomy.

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

Residential Treatment Center is an inpatient treatment Facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Disorder or Substance Abuse. The Facility must be licensed to provide psychiatric treatment of Mental and Nervous Disorders or rehabilitative treatment of Substance Abuse according to State and local laws and requires a minimum of one Physician visit per week in the Facility. Wilderness programs are not considered Residential Treatment Centers.

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

Serious Emotional Disturbances of a Child is 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

DEFINITIONS

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 (1) 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.
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Service Area is the geographic area within the State of California within which this Agreement is offered and issued.

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

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

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

For purposes of Severe Mental Illness and Serious Emotional Disturbances of a Child only, a Skilled Nursing Facility will also include a Residential Treatment Center.

Specialist (Specialty Care Physician \ Provider or SCP) A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Special Circumstances are those requiring services that are received from an Out of Network Provider with an Authorized Referral or in a Medical Emergency.

DEFINITIONS

Specialty Drugs: Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These Drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail Pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

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

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

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at an originating site and the health care Provider is at a distant-site. Telehealth facilitates patient self-management and caregiver support for patients and includes real-time interactions and the transmission of a patient's medical information from an originating site to the distant site without the presence of the patient. The originating site and the distant-site are licensed to provide Telehealth according applicable law.

Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non-preferred and high cost Drugs. This includes Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier contains high cost Drugs that may be Generic, single source Brand Drugs or multi-source Brand Drugs.

DEFINITIONS

Customer Service 1-855- [REDACTED]

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

You and Your means the Subscriber and any Dependents covered under this Agreement.

Specimen

DEFINITIONS

Customer Service 1-855-████████████████████

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HOW TO CONTACT US

If You have any questions about the information provided, please feel free to contact us.

For information about...	Contact	Phone Number	Address
Enrollment	Membership	1-855-383-7247	████████████████████ P.O. Box 9051 Oxnard, CA 93031-9051
Medical Benefits & Claims	Claims	1-855-383-7247	████████████████████ P.O. Box 60007 Los Angeles, CA 90060-0007
Hearing and Speech Impaired Customer Service	Customer Service	TTY 1-877-206-4966	
Precertification	Medical Management	1-800-274-7767	

████████████████████ provides convenient information regarding Your coverage.

Within the "Members" section of our site, many of Your questions can be answered quickly and easily. For instance, You can:

- Locate Preferred In Network Hospitals and In Network Providers
- Check status of Your claims and download claim forms
- Access health content and tools from WebMD®
- Review Your health insurance Plan's benefits and special offers
- Learn about Pharmacy benefits and Your Plan's Health Programs

If You want secure access to all the features the website has to offer, log onto www.anthem.com/ca, select "Members" and follow the prompts for registering. If You opted to receive Your contract materials electronically, this is also the link to use to view that information (if applicable). You will need Your ██████████ ID number, which is located on Your health identification card.

HOW TO CONTACT US

Customer Service 1-855-██

This Agreement is subject to all the definitions, limitations, exclusions and conditions as stated herein. Authorized officers of ██████████ have approved this Agreement.

██

Mark Morgan

Kathy Kiefer

Mark Morgan
President

Kathy Kiefer
Secretary

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HOW TO CONTACT US

APPENDIX I – YOUR RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities to help make sure that You get the most from this Plan. It helps You know what You can expect from Your overall health care benefit 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 is covered under this Plan.
- Work with Your doctors in making choices about Your health care.
- **Be treated with respect and dignity.**
- **Privacy** of Your personal health information, as long as it follows **State and federal laws** and our privacy policies.
- 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 this Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, Your coverage, or care received.
- 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.
- 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.

You have the **responsibility** to:

- Choose a network Primary Care Physician (doctor), also called a PCP, if Your Plan requires it.
- **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.

YOUR RIGHTS AND RESPONSIBILITIES

Customer Service 1-855- [REDACTED]

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- 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.
- 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 coverage and insurance benefits You have in addition to Your coverage with us.
- Tell Your doctors or other health care professionals if You don't understand any care You are getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with Your Doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let our customer service department know if You have any changes to Your name, address or Dependents covered under Your Plan.

If You have any questions or need additional information, call customer service at 1-855- [REDACTED]

YOUR RIGHTS AND RESPONSIBILITIES

APPENDIX II – SUBSCRIBER AND PREMIUM INFORMATION

[REDACTED]

Issued by

[REDACTED]

AGREEMENT NAME:
CONTRACT CODE:
SUBSCRIBER'S NAME:
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
SUBSCRIBER'S [RESIDENTIAL]ADDRESS
MONTHLY PREMIUM:
PREMIUM RATE EFFECTIVE DATE:
Please review this information carefully and if it is incorrect please inform Your agent or [REDACTED] immediately.

SUBSCRIBER AND PREMIUM INFORMATION