Anthem Blue Cross

Individual PPO Basic $1,000
7900 (1518, PE25, PE26)

Revised 9-01-08

Dear Anthem Blue Cross Life and Health Insurance Company Insured,

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

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

If you have any questions regarding your eligibility or membership please contact our customer service department toll free at 1-800-333-0912 or you may write to us at Anthem Blue Cross Life and Health Insurance Company at P.O. Box 9051 Oxnard, California 93031-9051.

If you have any questions regarding claims status or your benefits under this Policy, please contact us at 1-800-333-0912 or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 60007 Los Angeles, CA 90060-0007.

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

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

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

Nancy L. Purcell
Secretary
Anthem Blue Cross Life and Health
Insurance Company

TABLE OF CONTENTS

7900 (1518, PE25, PE26)

ANTHEM BLUE CROSS LIFE AND HEALTH

PPO BASIC $1,000

A Prudent Buyer Plan

Issued By
ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY

INTRODUCTION

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

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

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

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

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

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

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

In this Policy, "we," "us" and "our" mean Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) (Anthem). You are the eligible Policyholder whose individual enrollment application has been accepted by us. "You" and "your" also mean any eligible Dependents who were listed on your individual enrollment application and accepted by us for coverage under this Policy. When we use

the word “Insured” in this Policy, we mean you and any eligible Dependents who are covered under this Policy.

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

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

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

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

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

CHOICE OF CONTRACTING HOSPITAL, SKILLED NURSING FACILITY AND ATTENDING PHYSICIAN

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

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

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

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

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

IMPORTANT!

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

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

PART I ELIGIBILITY

Who is Eligible for Coverage

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

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

- The Policyholder's lawful spouse of the opposite sex.
- The Policyholder's Domestic Partner, subject to the following:
  The Policyholder and Domestic Partner have completed and filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code. The Domestic Partner does not include any person who is covered as a Policyholder or Spouse.
- Any children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are under age 19 and
- Any unmarried children of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner who are between their 19^{th} and 23^{rd} birthday, provided they are dependent upon them for at least half of their support. If your Dependent does not continue to meet the qualifications to remain as a dependent on your Policy, but is a resident of California, Anthem will automatically offer your Dependent the same Policy under his/her own identification number.
- Any of the Policyholder's, the Policyholder's enrolled spouse's or enrolled Domestic Partner's children who continue to be both incapable of self-sustaining employment due to a continued physically or mentally disabling injury, illness, or condition and who are dependent upon the Policyholder, enrolled spouse or enrolled Domestic Partner for support. Ninety (90) days before the dependent child reaches the limiting age, Anthem Blue Cross Life and Health will issue a request for proof that the child continues to meet the criteria for continued coverage. The Policyholder must submit written proof of such dependency within sixty (60) days of receiving the request. Before the date the child reaches the limiting age, Anthem Blue Cross Life and Health will determine whether the child meets the criteria for continued coverage. Two (2) Years after receipt of the initial proof, we may require no more than annual proof of the continuing handicap and dependency.

  Anthem Blue Cross Life and Health may request a new Policyholder to provide information regarding a dependent child with a continued physically or mentally disabling injury, illness or condition at the time of enrollment and not more than annually thereafter for proof that the child meets the criteria for continued coverage. The Policyholder must submit written proof of such dependency within sixty (60) days of receiving the request.
- Newborns of the Policyholder, the Policyholder's enrolled spouse or enrolled Domestic Partner for the first thirty-one (31) days of life. TO CONTINUE COVERAGE, THE NEWBORN MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF BIRTH AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE OF BIRTH.

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

- A child being adopted by the Policyholder will have coverage up to thirty-one (31) days from the date on which the adoptive child's birth parent or appropriate legal authority signs a written document granting the Policyholder, enrolled spouse or enrolled Domestic Partner the right to control health care for the adoptive child or absent this document the date on which other evidence exists of this right. TO CONTINUE COVERAGE, THE ADOPTED CHILD MUST BE ENROLLED AS A DEPENDENT BY NOTIFYING US IN WRITING WITHIN SIXTY (60) DAYS OF THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED AND THE POLICYHOLDER WILL BE RESPONSIBLE FOR ANY ADDITIONAL PREMIUMS DUE EFFECTIVE FROM THE DATE THE POLICYHOLDER'S AUTHORITY TO CONTROL THE CHILD'S HEALTH CARE IS GRANTED.

PART II WHEN AN INSURED BECOMES INELIGIBLE

An Insured becomes ineligible for coverage under this Policy when:

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

Notice of Change in Eligibility

You must notify us of all changes affecting any Insured's eligibility under this Policy except for the first and last bullets listed above under **An Insured becomes ineligible for coverage under this Policy.**

Options in the Event of Changed Circumstances

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

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

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

The written application must be submitted to us within thirty-one (31) days of the loss of eligibility. We will not need proof of good health.

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

PART III MAXIMUM COMPREHENSIVE BENEFITS

LIFETIME MAXIMUM

The combined total for all medical benefits is limited to a maximum amount of $5,000,000 per Insured during the Insured's lifetime, so long as this Policy remains in effect.

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

DEDUCTIBLE

Your Yearly Deductible for Covered Services is $1,000 per Insured per Year. During each Year, each Insured is responsible for all expenses incurred up to the Deductible amount. This Deductible is not prorated for a partial Year. Only Covered Expense will apply toward the Deductible. A claim must be submitted in order for us to record your eligible covered Deductible expense. We will record your Deductible in our files in the order in which your claims are processed, not necessarily in the order in which you receive the service or supply. The first two (2) Insureds of an enrolled family to satisfy their Deductible in full will satisfy the Deductible for the entire family. Once the family Deductible is satisfied, no further Deductible is required for the remainder of that Year. However, we will not credit any Deductible over and above the family Deductible maximum that was applied but did not satisfy an individual Insured's Deductible amount in full.

If you submit a claim for services which have a maximum payment limit (e.g., Mental or Nervous Disorders and Substance Abuse, not including the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child) and your Deductible is not satisfied, we will apply only the allowed per visit or per day amount, whichever applies, toward your Deductible.

YEARLY COPAYMENT/COINSURANCE MAXIMUM

The Yearly Copayment/Coinsurance Maximum is the amount of Copayment/Coinsurance that each Insured Person is required to pay for Covered Services in a calendar Year. Hospital admission charges and Copayments for not obtaining Preservice Review will not count toward satisfying your Yearly Copayment/Coinsurance Maximum and will continue to be required even after your Yearly Copayment/Coinsurance Maximum has been reached. The first two (2) Insureds of an enrolled family to reach their Yearly Copayment/Coinsurance Maximum in full will satisfy the Yearly Copayment/Coinsurance Maximum for the entire family. Once the family Yearly Copayment/Coinsurance Maximum is satisfied, no family member will be required to pay Copayment/Coinsurance amounts, except as otherwise required by this Policy for the remainder of that Year.

Charges for services that are not covered or charges exceeding our payment, such as Physician charges above the Negotiated Fee Rate or Customary and Reasonable charges are your responsibility. These charges do not count toward the Yearly Copayment/Coinsurance Maximum and may cause your payment responsibility to exceed the Yearly Maximum Out of Pocket for Covered Services and Covered Charges, which is defined immediately below.

YEARLY OUT OF POCKET MAXIMUM FOR COVERED SERVICES AND COVERED CHARGES

The Yearly Out of Pocket Maximum for Covered Services and Covered Charges is the sum of the Deductible and Yearly Copayment/Coinsurance Maximum. Since your policy has a yearly Deductible of $1,000 and a Yearly Copayment/Coinsurance Maximum of $2,500, then the Yearly Out of Pocket Maximum for Covered Services and Covered Charges is $3,500. After you have satisfied the Yearly Out of Pocket Maximum for Covered Services and Covered Charges, Anthem will provide benefits as follows:

BENEFIT	YOUR PAYMENT RESPONSIBILITY

INPATIENT HOSPITAL

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

Preferred Participating Hospital	No Copayment required for Covered Services for the remainder of the Year.
Participating Hospital	No Copayment required for Covered Services for the remainder of the Year.*
Non-Participating Hospital (in or out of CA)	All charges in excess of $650 per day for Covered Services.

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible or Yearly Copayment/Coinsurance Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery under the PART entitled Comprehensive Benefits: What Is Covered.

OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM SERVICES

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

Preferred Participating Hospital	No Copayment required for Covered Services for the remainder of the Year.
Participating Provider	No Copayment required for Covered Services for the remainder of the Year.*
Non-Participating Hospital (in or out of CA)	All charges in excess of $380 per day for Covered Services.

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

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible or Yearly Copayment/Coinsurance Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

BENEFIT	YOUR PAYMENT RESPONSIBILITY
SKILLED NURSING FACILITY This does not include treatment for Mental or Nervous Disorders or Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child).	
Participating Hospital	No Copayment required for Covered Services for the remainder of the Year.
Non-Participating Hospital (in or out of CA)	All charges in excess of $150 per day for Covered Services.
MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE This does not include treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.	
Participating Providers	**Inpatient Services:** All of the Covered Expenses **except** $175 per day.
Non-Participating Provider	**Inpatient Services:** All of the Covered Expenses **except** $175 per day. **Outpatient Services:** All of the Covered Expenses **except** $25 per visit, 20 visits per Year maximum.

Note: Benefits are provided up to a maximum payment of $5,250 per Year, thirty (30) days per Year, for Participating and Non-Participating Providers combined.

PROFESSIONAL SERVICES FOR LIST A	
Participating Providers	No Copayment required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Negotiated Fee Rate for Covered Services for the remainder of the Year.

List A

- Services of a Physician (including surgeons and specialists and home and office visits).
- Services of an anesthesiologist or anesthetist
- Outpatient diagnostic radiology.
  Note: The following procedures require Preservice Review.
  - Computerized Tomography (CT) scan
  - Positron Emission Tomography (PET) scan
  - Magnetic Resonance Imaging (MRI) scan
  - Magnetic Resonance Spectroscopy (MRS) scan
  - Nuclear Cardiology (NC) scan
- Outpatient diagnostic radiology
- Outpatient diagnostic laboratory
- Medical supplies and equipment rental or purchase of dialysis equipment and supplies and other long lasting medical equipment and supplies when ordered by your Physician. The equipment or supply must be for medical use to treat a health problem and only for the use of the person for whom it was prescribed. Rental charges that exceed the reasonable purchase price of the equipment are not covered.
- Hemodialysis treatment

- Footwear services in relation to preparation and dispensing of custom footwear necessary to treat an injury or illness. Footwear is limited to a maximum benefit of $400 per Year combined for Participating and Non-Participating Providers.
- Outpatient professional treatment of Mental or Nervous Disorders and Substance Abuse. Limited to $25 per visit, one (1) visit a day and 20 visits per Year for Participating and Non-Participating Providers combined.
- Infusion Therapy. If services are performed in the home, those services must be billed and performed by a provider licensed by state and local laws.
  Note: A course of treatment is defined as Physician prescribed Infusion Therapy for a period of ninety (90) days or less.

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

  Covered Services for Infusion Therapy will not include:
  - compounding fees (charges for mixing or diluting drugs, medicines or solutions) or
  - incidental supplies (disposable items such as cotton swabs, tubing, syringes and needles for drugs, Band-Aids and intravenous starter kits).

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

  Infusion Therapy benefits will not be provided for:
  - Drugs and medicines not requiring a prescription.
  - Drugs labeled "Caution, limited by federal law to investigational use" or drugs prescribed for experimental use.
  - Drugs or other substances obtained outside the United States.
  - Non-FDA approved homeopathic medications or other herbal medications.
  - Charges exceeding the Average Wholesale Price of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product.

PROFESSIONAL SERVICES FOR LIST B

BENEFIT	**YOUR PAYMENT RESPONSIBILITY**
Participating Providers	No Copayment required for Covered Services for the remainder of the Year.
Non-Participating Provider	50% of the Customary and Reasonable charge for Covered Services for the remainder of the Year.

List B
- Services of a nurse
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.
- Outpatient speech therapy when following surgery, injury or non-congenital organic disease, limited to 50 visits per Year.
- Surgical implants
- Artificial limbs or eyes
- The first pair of contact lenses or eyeglasses when required as a result of covered eye surgery.

PART IV BENEFIT COPAYMENT/COINSURANCE LIST

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

DETERMINATION OF COVERED EXPENSE

- Covered Expense is the expense incurred, up to the maximum described in the next bullet, for a Covered Service or supply. Expense is incurred on the date the Insured receives the service or supply for which the charge is made. **Please review the specific benefit under this PART for any per day, visit or Year limitation and review the PART entitled MAXIMUM COMPREHENSIVE BENEFITS for your lifetime maximum, which may be applied to a particular benefit.**
- In no event will Covered Expenses exceed:
  - Any charge for services of a Participating or Preferred Participating Hospital, participating Physician, Participating Skilled Nursing Facility, Participating Hospice, Participating Ambulatory Surgical Center, Participating Home Health Care provider or Participating Infusion Therapy provider in excess of the Negotiated Fee Rate.
  - Any charge for services of a Non-Participating Physician in excess of the Negotiated Fee Rate except if Special Circumstances apply in which case Covered Expense will not exceed Customary and Reasonable charge.*
  - Any charge for services of a Non-Participating Hospital in excess of a Reasonable Charge.*
  - Any charge for services of a Non-Participating Ambulatory Surgical Center, Hospice, Skilled Nursing Facility or Home Health Care provider in excess of a Customary and Reasonable charge.*
  - Any charge in excess of $50 per day for administrative and professional services of a Non-Participating Infusion Therapy provider; or any charge in excess of the Average Wholesale Price for Drugs provided by a Non-Participating Infusion Therapy provider. **The combined maximum Covered Expense for a Non-Participating Infusion Therapy provider will not exceed $500 per day for all Drugs, professional and administrative services.**
  - Any charge in excess of a Reasonable Charge for all other covered providers, services and supplies for which Anthem does not enter into Prudent Buyer Participating Agreements.

Your personal financial costs when using Non-Participating Providers will be considerably higher than when you use Participating Providers. You will be responsible for any balance of a provider's bill which is above the allowed amount payable under this Policy for Non-Participating Providers.*

Most Hospitals in California are either Participating Hospitals or have another contract with us. No benefits are provided for the few Non-Contracting Hospitals within California for inpatient Hospital services or outpatient surgical procedures except as specifically stated in the section entitled, **Special Circumstances**.

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

SECOND OPINIONS

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

COPAYMENTS/COINSURANCE

You will be required to pay a Copayment/Coinsurance for services received while you are covered under this Policy. Your Copayment/Coinsurance may be a fixed dollar amount per day, per visit or it may be a percentage of eligible charges. It could also be a combination of a fixed dollar amount and a percentage of eligible charges. Hospital admission charges and some Copayments/Coinsurance (e.g., Copayments for not obtaining Preservice Review) **will not** be applied toward your Yearly Copayment/Coinsurance Maximum and **will continue to be required** even after your Yearly Copayment/Coinsurance Maximum has been reached. **Refer to the following Copayment/Coinsurance list to determine your Copayment/Coinsurance responsibility for Covered Services for Participating/Preferred Participating and/or Non-Participating Providers.**

BENEFIT	**YOUR PAYMENT RESPONSIBILITY**
INPATIENT HOSPITAL	
Preferred Participating Hospital	20% of the Negotiated Fee Rate.
Participating Hospital	20% of the Negotiated Fee Rate.*
Non-Participating Hospital	All charges in excess of $650 per day for Covered Services unless **Special Circumstances** apply. This includes treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible or Yearly Copayment/Coinsurance Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

A Center of Medical Excellence (CME) Network has been established for transplants and bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss. These procedures are covered only when performed by a Participating Provider at an approved CME facility, except for Medical Emergencies. For more information, please see the section entitled Centers of Medical Excellence (CME) for Transplants and Bariatric Surgery under the PART entitled Comprehensive Benefits: What Is Covered.

BENEFIT	YOUR PAYMENT RESPONSIBILITY
OUTPATIENT HOSPITAL, AMBULATORY SURGICAL CENTERS AND EMERGENCY ROOM	
Preferred Participating Provider	20% of the Negotiated Fee Rate.
Participating Provider	20% of the Negotiated Fee Rate.*
Non-Participating Provider	All charges in excess of $380 per day for Covered Services unless **Special Circumstances** apply. This includes treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

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

*The Insured is responsible for a $500 admission charge per admission for inpatient services or when an outpatient visit is related to surgery or Infusion Therapy at a Participating Hospital. This admission charge is separate from any Deductible required by this Policy. It does not apply toward satisfying the Insured's Yearly Deductible or Yearly Copayment/Coinsurance Maximum. The admission charge will not be required for Medical Emergency admissions or Ambulatory Surgical Centers.

SKILLED NURSING FACILITY Limited to 100 days per Year combined for Participating and Non-Participating Providers.	
Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider and out of state provider	All charges in excess of $150 per day for Covered Services unless **Special Circumstances** apply. This includes treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.
AMBULANCE	
Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider	**Ground Ambulance**: All charges in excess of $750 per trip **plus** 50% of the Negotiated Fee Rate and all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply. **Air Ambulance:** 50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.
PREVENTIVE CARE For Insureds age 7 to adult. No Deductible applies. Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your yearly Deductible.	
Performed at HealthyCheck Centers only	$25 Basic Screening or $75 Premium Screening

This benefit does not apply to Non-Participating Providers.

DENTAL INJURY	
Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate unless **Special Circumstances** apply.

BENEFIT	YOUR PAYMENT RESPONSIBILITY

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE
This does not include treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child. The payments for this benefit will not be applied toward the Insured's Yearly Copayment/Coinsurance Maximum.

Participating or Preferred Participating Provider	All of the Covered Expenses **except** $175 per day.
Non-Participating Provider	All of the Covered Expenses **except** $175 per day.

Note: Benefits are provided up to a maximum payment of $5,250 per Year, thirty (30) days per Year, for Participating and Non-Participating Providers combined.

SEVERE MENTAL ILLNESSES AND SERIOUS EMOTIONAL DISTURBANCES OF A CHILD
Benefits provided as any other medical condition.

Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

FOREIGN COUNTRY PROVIDERS
For initial treatment of a Medical Emergency only.

All providers	20% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.

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

OTHER ELIGIBLE PROVIDERS
The following class of providers do not enter into participating agreements with us and your payment responsibility for these providers is as indicated below: a blood bank, a dentist (D.D.S.), a dispensing optician, a speech pathologist, a respiratory therapist.

All providers listed above	20% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable.

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

HOME HEALTH CARE
Limited to sixty (60) visits per Year for Participating and Non-Participating Providers combined up to four (4) hours or less each visit.

Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider	All charges in excess of $75 per visit **plus** 50% of the Negotiated Fee Rate and all charges in excess of the Negotiated Fee Rate.

HOSPICE
Limited to a lifetime maximum of $10,000 for Participating and Non-Participating Providers combined.

Participating Provider	20% of the Negotiated Fee Rate.
Non-Participating Provider	50% of the Negotiated Fee Rate **plus** all charges in excess of the Negotiated Fee Rate.

BENEFIT	YOUR PAYMENT RESPONSIBILITY
SPECIAL CIRCUMSTANCES	
Authorized Referral	
Non-Participating Hospital Physician, Ambulatory Surgical Center (inpatient or outpatient)	20% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.
For Medical Emergencies Within California	
Emergency Room services received in the state of California are subject to an additional $100 Copayment per visit which is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services.	
Non-Participating Provider	**Professional Services:** 20% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable.
Non-Participating Providers	**Hospitals and Non-Contracting Hospitals:** 20% of Customary and Reasonable charges or billed charges, whichever is less, **plus** all charges in excess of Customary and Reasonable, for the first 48 hours. After 48 hours, **all** charges in excess of $650 per day.* **Ambulatory Surgical Centers:** 20% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable. **Ground Ambulance:** 20% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable and in excess of $750 per trip. **Air Ambulance:** 20% of Customary and Reasonable charges plus all charges in excess of Customary and Reasonable.

*If the Insured can demonstrate to Anthem that his/her medical condition reasonably prevented transfer to a Participating facility after the first 48 hours, then the Insured's payment will remain at 20% of the Customary and Reasonable charge **plus** all charges in excess of Customary and Reasonable until his/her condition permits transfer to a Participating facility.

BLUECARD PROGRAM

For Medical Services Outside California

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

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

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

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

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

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

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

BlueCard Provider Types

PPO Providers

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

Traditional Providers

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

Non-Participating Providers

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

To locate a BlueCard PPO or Traditional provider when outside of California call 1-800-810 BLUE (2583) or visit the BlueCard website address: www.bcbs.com. When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

BENEFIT	YOUR PAYMENT RESPONSIBILITY
Medical Non-Emergencies Outside California	
Your payment responsibility for Covered Services received from non-participating providers, including ambulance, will be at the PPO provider percentage for emergency services as described below.	
Physician	
PPO Provider	20% of the BlueCard provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	50% of the BlueCard provider's Negotiated Price **plus** all charges in excess of the BlueCard provider's Negotiated Price.
Hospital or Ambulatory Surgical Center	
PPO Provider	20% of the BlueCard provider's Negotiated Price.
Traditional Provider*	50% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	**Inpatient Hospital:** You pay all charges in excess of $650 per day. **Outpatient Hospital and/or Ambulatory Surgical Centers:** You pay all charges in excess of $380 per day.

*If there are no BlueCard PPO providers in the area, your payment responsibility will be 20% of the BlueCard provider's Negotiated Price.

Medical Emergencies Outside California	
Your payment responsibility, for Covered Services received from non-participating Providers, including ambulance, will be at the Participating PPO provider percentage for emergency services as described below.	
Physician	
PPO Provider	20% of the BlueCard provider's Negotiated Price.
Traditional Provider	20% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	20% of the Customary and Reasonable charges **plus** all Charges in excess of Customary and Reasonable.
Hospital or Ambulatory Surgical Center	
PPO Provider	20% of the BlueCard provider's Negotiated Price.
Traditional Provider	20% of the BlueCard provider's Negotiated Price.
Non-Participating Provider	**Hospital:** 20% of the Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable Charges for the first 48 hours. After 48 hours, all charges in excess of $650 per day.** **Ambulatory Surgical Centers:** 20% of Customary and Reasonable charges **plus** all charges in excess of Customary and Reasonable.

If an Insured can demonstrate to Blue Cross and/or Blue Shield that his/her medical condition reasonably prevented transfer to a BlueCard PPO or Traditional facility after the first 48 hours, then the Insured's payment will remain at 20% of Customary and Reasonable charges **plus all charges in excess of Customary and Reasonable, until his/her medical condition permits transfer to a PPO or Traditional facility.

PART V COMPREHENSIVE BENEFITS: WHAT IS COVERED

COVERED SERVICES

Before we pay for any benefits, you must satisfy your Deductible. The medical Deductible is described in the section DEDUCTIBLE under the PART entitled BENEFIT COPAYMENT/COINSURANCE LIST.

All Covered Services are subject to the Yearly Deductible including limited benefits such as, Home Health services and Mental or Nervous Disorders and Substance Abuse.

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

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

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

Covered Inpatient Services

- A Hospital room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Services in Special Care Units.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, radiology and any professional component of these services.
- Physical Therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines approved by the Food and Drug Administration which are supplied by the Hospital for the illness, injury or condition for which the Insured is hospitalized, including take-home drugs billed on the Insured's inpatient Hospital bill and dispensed by the Hospital's pharmacy at the time of the Insured's discharge from the Hospital.
- Blood transfusions, but **not** the cost of blood, blood products or blood processing.

Covered Outpatient Services

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

Conditions of Service

- Services must be those which are regularly provided and billed by a Hospital.
- Services must be received in a Contracting Hospital, except for surgical services received at an Ambulatory Surgical Center.
- Emergency room care must be for the first treatment of a Medical Emergency as defined in the PART entitled DEFINITIONS.
- Emergency room care for an injury must be received within 72 hours of the injury date.
- NO OUTPATIENT HOSPITAL BENEFITS ARE PAYABLE FOR ANY PHYSICIAN'S CHARGES EXCEPT FOR THE SERVICES OF A HOSPITAL-EMPLOYED PHYSICIAN IN CONNECTION WITH A COVERED OUTPATIENT HOSPITAL SERVICE.

PRE-ADMISSION TESTING

Routine X-ray and laboratory examinations, received in a Hospital setting only, required in connection with a covered surgery for which a Hospital confinement is Medically Necessary. These examinations must be performed within seven (7) days prior to the Hospital confinement.

No benefits will be provided if:
- the X-ray and laboratory examinations are performed to establish or confirm a diagnosis or
- the services are repeated when the Insured is admitted to the Hospital as an inpatient or
- an Insured cancels or postpones the admission to the Hospital.

SKILLED NURSING FACILITY

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

Benefits for Covered Services are provided according to the following:
- A room with two or more beds. If a private room is used, we will only allow up to the prevailing two-bed room rate.
- Special treatment rooms.
- Laboratory tests.
- Physical, occupational and speech therapy. Oxygen and other respiratory therapy.
- Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.
- Blood transfusions, but not the cost of blood, blood products or blood processing.

Conditions of Services

- The Insured must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the illness, injury, degree of disability and medical needs of the Insured. Benefits are provided only for the number of days required to treat the Insured's illness or injury.
- Benefits are provided if a Skilled Nursing Facility stay is needed outside California.

AMBULANCE

Benefits for Covered Services are provided according to the following:
- Base charge and mileage to transport you to or from a Hospital or Skilled Nursing Facility when Medically Necessary.
- Non-reusable supplies.
- Monitoring, electrocardiograms (EKG's or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with the ambulance service. An appropriately licensed person must render the services.

Conditions of Services

- Services must be for ground or air ambulance transportation of the Insured to an acute care Hospital. Upon reaching the Hospital, the Insured must be admitted as an inpatient or receive emergency outpatient care as stated above.
- Services must be provided by a licensed ambulance company.

Maximums

- Non-Participating ground ambulance transportation benefits are limited to a maximum payment of $750 per trip. This maximum does not apply to air ambulance transportation.
- Payment of benefits for ambulance services will be made directly to the provider of the service unless proof of payment is received by us prior to the benefits being paid.
- If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if you are not transported to a Hospital.

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

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

LIMITED PROFESSIONAL SERVICES

- Services of a Surgeon for a covered surgical procedure.
- Services of an Assistant Surgeon for a covered surgical procedure.
- Services of an anesthesiologist or an anesthetist for a covered surgical procedure.
- Cancer screening tests approved by the federal Food and Drug Administration (FDA) and the office visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife. This includes screening for breast, cervical, ovarian and prostate cancer.
- Mammogram examinations and the office visit associated with performing those tests when ordered by your Physician, registered nurse practitioner or certified nurse midwife.
- Radium and radioactive isotope therapy whether performed on an inpatient or outpatient basis.
- Prosthetic devices to achieve symmetry after mastectomy.
- Hepatitis B and Varicella Zoster (chicken pox) vaccine for Dependents age 7 through 18 and the office visit associated with administering that vaccination when ordered by your Physician. Not subject to the Deductible.
- Reconstructive Surgery is defined as Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance to the extent possible.
- In Hospital Physician visits to an Insured during a covered Hospital confinement.
- Services of a Physician for diabetes education services.
- Services of a Physician or Dentist treating an Accidental Injury to your natural teeth when you receive treatment within one (1) Year following the injury. Damage to your teeth due to chewing or biting is not an Accidental Injury.

No benefits for Professional Services are provided for Mental or Nervous Disorders and Substance Abuse, **except for the treatment of Severe Mental Illnesses and Serious Emotional Disturbances of a Child**, whether the care is provided in an inpatient Hospital setting or as an outpatient.

No benefits are provided for professional services or any services or supplies not specifically listed in this section, such as, but not limited to:

- the services of a nurse
- physical or occupational therapist
- diagnostic X-rays, except mammogram examinations ordered by your Physician
- laboratory tests except cervical, ovarian and prostate cancer screenings and pre-admission testing
- drugs
- medicines
- prostheses
- medical equipment or
- blood and blood transfusions and
- home and office visits

PREVENTIVE CARE HEALTHYCHECK CENTERS
Insureds age 7 to adult

No Deductible applies. Copayments paid at HealthyCheck Centers do not accumulate toward satisfying your Yearly Deductible.

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

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

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

The following services available only at HealthyCheck Centers:

$25 Basic Screening (for children ages 7-17 and adults ages 18 and over) includes:

- Blood Pressure
- Height and weight
- Pulse and resting heart rate
- Heart, lung, thyroid and abdomen evaluation
- Body Mass Index (BMI)
- Skin cancer evaluation and education
- Tetanus-Diphtheria booster
- Tetanus-Diphtheria and Pertussis booster
- Flu Shot (per CDC guidelines and availability)

For adults only:
- Cholesterol: Total and HDL ("good")
- Glucose

For children only:
- Hemoglobin
- Urinalysis
- Vision and hearing screenings
- Measles-Mumps-Rubella booster
- Polio booster

$75 Premium Screening (for adults ages 18 and over) includes everything in the Basic Screening plus:
- Cholesterol: LDL ("bad")
- Triglycerides
- Colorectal cancer screening (per CDC guidelines)
- Urinalysis
- Vision screening
- Flexibility testing
- Body composition - body composition is the true definition of an individual's overweight status. HealthyCheck centers use a handheld machine that uses bioelectrical impedance t measure one's body fat.
- Posture analysis - a clinician will use a posture score sheet to grade each part of the member's posture, including head, shoulders, spine, hips, ankles, neck, upper back, trunk, abdomen and lower back.

Adult Preventive Services
The following services are provided at your Physician's office and not at the HealthyCheck Centers. The service, including the Office Visit related to that service, is not subject to the Deductible.
- Annual pap exam
- Breast exams
- Mammogram testing and appropriate screening for breast cancer
- Cervical and ovarian cancer screening tests
- Prostatic Specific Antigen (PSA) testing

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

Diabetes Equipment and Supplies

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

Diabetes Outpatient Self-Management Training Program

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

The following medications and supplies:

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

DENTAL

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

MENTAL OR NERVOUS DISORDERS AND SUBSTANCE ABUSE

This does not include the treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

For Covered Inpatient Hospital services see the section, HOSPITAL, at the beginning of this PART.

Conditions of Service

- Services must be for treatment of Substance Abuse, such as drug or alcohol dependence, or a Mental or Nervous Disorder which can be improved by standard medical practice.
- The Insured must be under the direct care and treatment of a Physician for the condition being treated.
- Services must be those which are regularly provided and billed by a Hospital.
- Services are provided only for the number of days required to treat the Insured's illness, injury or condition.
- Inpatient Hospital services and Day Treatment Program Centers are limited to $175 per day up to a maximum payment of $5,250 per Year, thirty (30) days per Year, for Participating and Non-Participating Providers combined.

Note: In California services must be received in a Contracting Hospital.

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

Benefits for Covered Services and supplies provided for the treatment of specific Severe Mental Illnesses and Serious Emotional Disturbances of a Child will be provided at the same levels of coverage as other medical diagnoses. These services are subject to all other terms, conditions, limitations and exclusions, including Maximum Comprehensive Benefits. See the PART entitled DEFINITIONS.

PHENYLKETONURIA (PKU)

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

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

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

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

CANCER CLINICAL TRIALS

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

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

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

Covered Services will not include the following:

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

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

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

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

Bariatric Surgery (requires Preservice Review): Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a CME facility. You or your Physician must obtain Preservice Review for all bariatric surgical procedures. **Preservice Review can be obtained by calling toll free 1-800-274-7767**. When you or your Physician calls for the required Preservice Review, we will advise you that such services must be performed at an Anthem CME.

Note: Charges for these bariatric surgical procedures and related services are covered only when the bariatric surgical procedures and related services are approved by Anthem and performed at an Anthem approved CME facility by a Participating Provider.

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

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

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at 1-800-333-0912. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

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

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

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

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

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

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

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

Travel expenses include:

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

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.

WIGS

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

HOME HEALTH CARE

Home Health Care providers are included in our Participating Provider network. The following services of a Home Health Agency or Visiting Nurse Association are provided up to sixty (60) visits per Year for Participating and Non-Participating Providers combined. A visit is defined as four (4) hours or less of service provided by one of the providers listed below.

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

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

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

HOSPICE

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

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

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

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

Benefits for Hospice services are limited to a lifetime maximum of $10,000 per Insured Person for Participating and Non-Participating Providers combined.

PART VI EXCLUSIONS AND LIMITATIONS

We will not furnish benefits for:

Acupuncture: Care or treatment provided through the use of acupuncture or acupressure.

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

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

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

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

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

Educational Services and Nutritional Counseling, except as specifically provided or arranged by us under the Diabetes Outpatient Self-Management Training Program provision in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

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

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

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

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

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

Hearing Aids: Hearing aids and routine hearing tests.

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

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

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

Non-Contracting Hospital: No benefits are provided for care or treatment furnished in a Non-Contracting Hospital except as described in the section entitled SPECIAL CIRCUMSTANCES under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED, in this Policy. This exclusion applies **only** in California.

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

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

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

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

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

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

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

Outdoor Treatment Programs

Outpatient Prescription Drugs: No benefits are provided for prescription or non-prescription drugs on an outpatient basis except as specifically stated in the sections, TREATMENT FOR DIABETES or HOSPITAL, under the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

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

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

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

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

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

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

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

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

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

Telephone and Facsimile Machine Consultations

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

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

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

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

PART VII UTILIZATION MANAGEMENT AND PRESERVICE REVIEW

IMPORTANT: Utilization Management and Preservice Review does not guarantee that you have coverage or that benefits will be paid, nor does it guarantee the amount of benefits to which you are entitled. The payment of benefits is subject to all other terms, conditions, limitations and exclusions of this Policy. All Covered Services are subject to review by Anthem for medical necessity.

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

Preservice Review. You are always responsible for initiating Preservice Review. Anthem will determine **in advance** whether certain procedures and admissions are Medically Necessary and are the appropriate length of stay, if applicable. Whenever Preservice Review has not been performed you will be required to pay a $250 Copayment. **This Copayment is in addition to any other Copayment required by this Policy and will NOT apply toward satisfying your Yearly Copayment/Coinsurance Maximum. This Copayment is not required in Medical Emergencies.**

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

Preservice Review is <u>required</u> for, but not limited to:

- All elective, urgent or emergent inpatient Hospital admissions (except for mastectomy surgery, including the length of Hospital stays associated with mastectomy).
- Facility Based Treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child and Mental or Nervous Disorders or Substance Abuse.
- Centers of Medical Excellence (CME) procedures (including organ and tissue transplants and bariatric surgery)
- The following diagnostic and radiological procedures wherever performed:
  - Magnetic Resonance Imaging (MRI) scan
  - Magnetic Resonance Spectroscopy (MRS) scan
  - Computerized Tomography (CT) scan
  - Positron Emission Tomography (PET) scan
  - Nuclear Cardiology (NC) scan
- Other specific procedures, wherever performed, as specified by Anthem. For a list of current procedures, please contact Anthem toll free at 1-800-274-7767 or visit our website at www.anthem.com/ca.

Admission Review. Anthem will determine at the time of admission if the service is Medically Necessary in the event Preservice Review is not conducted (except for inpatient Hospital stays related to mastectomy surgery, including the length of Hospital stays associated with mastectomy).

Continued Stay Review. Anthem will also determine if a continued Hospital stay is Medically Necessary. The length of Hospital stays related to mastectomy will be determined by the treating Physician in consultation with the patient.

Retrospective Review. Anthem will determine if any service was Medically Necessary in the event that Preservice Review, admission review or continued stay review was not performed.

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

PART VIII ALTERNATIVE BENEFITS

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

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

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

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

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

Alternative benefits paid are accumulated toward any Annual or Lifetime Maximums under the Policy.

PART IX GENERAL PROVISIONS

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

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

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

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

- The Insured must be under the care of the Participating Provider at the time of our termination of the provider’s participation. The terminated provider must agree in writing to provide services to the Insured in accordance with the terms and conditions of his/her agreement with Anthem prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Anthem prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider’s services beyond the contract termination date.

- Anthem will furnish such benefits for the continuation of services by a terminated provider only for any of the following conditions:
  - an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
  - A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by Anthem in consultation with the Insured and the terminated provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
  - a pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
  - A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
  - The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the provider's contract termination date.
  - Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the provider's contract termination date.
- Such benefits will not apply to providers who voluntarily leave their provider group network, providers who choose not to renew their agreement, or providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity.
- Please contact customer service toll free at 1-800-333-0912, to request continuation of care or to obtain a copy of the written policy. Eligibility is based on the Insured's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Policy.

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

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

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

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

Out of California Providers: The Blue Cross and Blue Shield Association, of which we are a member/Independent Licensee, administers a program called the BlueCard Program, in which we participate, which allows our Insureds to have the reciprocal use of Participating Providers that contract with other Blue Cross and/or Blue Shield Plans. Providers available to you through the BlueCard Program have

not entered into contracts with Anthem. If you have any questions or complaints about the BlueCard Program, please call us at 1-800-333-0912. If you are traveling outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield Participating Provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate with a local Blue Cross and/or Blue Shield Plan. In order for you to receive access to whatever reductions in out-of-pocket expenses may be available, we must abide by the BlueCard Program rules, as set by the Blue Cross and Blue Shield Association.

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

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

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

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

When traveling outside the United States, in cases of emergencies only, call 1-800-810-BLUE (2583) to inquire about providers that may participate in the BlueCard Worldwide Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

Terms of Coverage

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

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

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

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

PART X INDEPENDENT MEDICAL REVIEW OF GRIEVANCES

If an Insured has had any Covered Service denied, modified or delayed or has had coverage denied because proposed treatment is determined by us to be investigational or experimental or not Medically Necessary, the Insured may ask for review of that denial, modification or delay by an external independent medical review organization. To request a review, please call 1-800-333-0912 or write to us at Anthem Blue Cross Life and Health Insurance Company P.O. Box 9051 Oxnard, California 93031-9051. To request an Independent Medical Review (IMR) from the California Department of Insurance (DOI), all of the following conditions must be satisfied.

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

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

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

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

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

"Acceptable scientific support" is the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards,

- Medical journals recognized by the Secretary of Health and Human Services under Section 1861 (t) (2) of the Social Security Act,
- The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and the United States Pharmacopeia-Drug Information,
- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research,
- 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.

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

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

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

AND

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

General

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

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

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

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition

letter that denies, modifies or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

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

PART XI BINDING ARBITRATION

Any dispute or claim arising out of this Policy or breach thereof, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court.

Any disputes regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Policyholder and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to a trial by jury for <u>both</u> medical malpractice claims and any other disputes.

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. With respect to an arbitration held in California, should the Federal Arbitration Act not apply, the California Arbitration Act, Code of Civil Procedure Sections 1280, et seq., shall apply.

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

Should damages claimed be $50,000.00 or less, the arbitration shall be held by a single, neutral arbitrator mutually agreed to by the parties. Such arbitrator shall have no jurisdiction to award more than $50,000.00. The arbitrator shall be selected in accordance with the applicable rules of the arbitration administration entity. With respect to an arbitration held in California, if the parties are unable to agree on the selection of an arbitrator using the rules of the arbitration administration entity, the method provided in Code of Civil Procedure Section 1281.6 shall be used.

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

The Policyholder and Anthem agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations the Policyholder waives any right to pursue, on a class basis, any such controversy or claim against Anthem and Anthem waives any right to pursue on a class basis any such controversy or claim against the Policyholder.

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

Anthem will provide Policyholders, upon request, with an application, or information on how to obtain an application from the neutral arbitration entity, for relief of all or a portion of their share of the fees and expenses of the neutral arbitration entity. Approval or denial of an application in the case of extreme financial hardship will be determined by the neutral arbitration entity.

Please send all Binding Arbitration disputes to:

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

COMPLAINTS

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

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

If you have any questions regarding your eligibility or membership, please contact our customer service department toll free at 1-800-333-0912, or you may write to us at:

Life & Health Insurance Company
P.O. Box 9051
Oxnard, CA 93031-9051

DEPARTMENT OF INSURANCE

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

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

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

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

B. The duration of your coverage under this Policy depends on how your premiums are billed, and is equal to the length of time between billing cycles. For example, if we bill premiums on a bi-monthly basis, your coverage is for a two-month duration. If we bill premiums on a quarterly basis, your coverage is for a three-month duration. If you have chosen Anthem's monthly checking account deduction program, or are a member of a list bill program, or if we otherwise bill premiums on a monthly basis, your coverage is for a one-month duration. The duration of the Policy is determined by how you pay your premiums (measured from the effective date of coverage) and is unrelated to, and is not affected by, the use of other periods of time to measure or determine your rights or benefits, such as, for example, the use of a calendar year or other Deductibles.

C. Although your Policy expires at the end of each billing cycle, it will, upon timely payment of the billed premiums, automatically renew under the same terms and conditions unless (1) Anthem has terminated, canceled, or declined to renew the Policy pursuant to Paragraph D. below; or (2) Anthem has modified the Policy pursuant to Paragraph E. below. In the case of a modification under Paragraph E., the Policy will renew for the term specified in Paragraph B. above under the modified terms and conditions.

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

1. When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If you fail to pay premiums as they become due, Anthem may terminate this Policy as of the last day of the grace period described above. Nevertheless, Anthem will terminate this Policy only upon first giving you a written Notice of Cancellation at least fifteen (15) days prior to that termination. The Notice of Cancellation shall state that this Policy shall not be terminated if you make appropriate payment in full within fifteen (15) days after Anthem issues the Notice of Cancellation. You are not entitled to a grace period until you have made your first payment to us. If you need covered benefits during the grace period, coverage will be provided. However, we will deduct the premiums due for coverage continued during the grace period from any benefits we pay.

   The Notice of Cancellation also shall inform you that, if this Policy is terminated for non-payment of premiums, you may apply for reinstatement by submitting a new application and any premiums that are owed. See the section Reinstatement under the PART entitled GENERAL PROVISIONS for information on our reinstatement provision.

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

3. For fraud or misrepresentation in certain situations. Misrepresentation or omissions on the application may result in termination or rescission of this Policy. This Policy may also be terminated if you knowingly participated in or permitted fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or misrepresentation will be effective as of the Effective Date of coverage in the case of rescission.

4. For fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.

5. Upon becoming ineligible for this coverage. See the PART entitled WHEN AN INSURED BECOMES INELIGIBLE.

E. Notice to Cancel or Cease Coverage

1. Before we will cease to provide any new or existing individual health benefit Policy:

   a. We will give you at least 180 days written notice prior to cessation of this Policy and
   b. Those individual health benefit Policies that are in effect shall not be canceled for 180 days, after the day of notification to cease coverage, except for specific non-compliance previously stated under B. of this PART.

2. We will give you ninety (90) days written notice before we withdraw this individual health benefit Policy from the health care market.

3. In addition to the right to terminate, cancel or decline to renew the Policy set forth in Paragraph D., Anthem has the right upon renewal, or at any time during the duration of your Policy, to modify or otherwise change the terms and conditions of your Policy, **including premiums**, provided that Anthem gives you thirty (30) days written notice of such modifications or changes. Such modifications or changes may alter <u>any</u> term or benefit of this Policy, including without limitation, premiums, covered benefits, Deductibles, copayments or coinsurance. Anthem can modify or change the terms and conditions of your Policy at any time during the Year on thirty (30) days written notice, regardless of whether your Deductible or other cost sharing provisions are calculated on an annual or calendar-year basis.

   a. In addition to the thirty (30) days written notice provision set forth above, Anthem's right to modify this Policy under Paragraph E. 3. is subject to the following conditions:

      i. We will not cancel or modify this Policy under this Paragraph E., 3. on an individual basis but only for all Insureds in the same class and covered under the same Policy as you, except:
         (a) if we discover any fraud or intentional misrepresentation of material fact under the terms of the coverage by an individual,
         (b) if we find out about any fraud or deception in the use of the benefits of this Policy by you, your enrolled family or anyone else if you or any Insured of your family knows about it.

      ii. The modifications or changes will take effect upon the next applicable renewal date occurring (determined as provided in Paragraph A. above) on or after the 30th day following the date of the above notice.

4. If, on the date we cancel your coverage on written notice (except for the reasons described in E., 1. a. and b.) you are suffering from either an injury sustained or an illness arising while your coverage under this Policy was in effect, benefits will continue, but limited by and subject to all of the following:

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

   c. All conditions, reductions, limitations and exclusions of this Policy, including any benefit maximums, will apply to these continued benefits. In no event will benefits in excess of any maximum benefits be provided.

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

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

PART XIII NON-DUPLICATION OF ANTHEM BENEFITS

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

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

PART XIV DEFINITIONS

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

Accidental Death and Dismemberment Maximum Benefit is the total amount of the benefit that the Accidental Death and Dismemberment insurance provides.

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

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

Attained Age is your age at the time of each of your premium billings. Your premiums are based upon your Attained Age. We will recalculate your age for each billing and your premiums will be adjusted accordingly.

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

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

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

Beneficiary is a person or entity named to receive benefits.

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

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

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

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

Cosmetic and Reconstructive Surgery: Cosmetic Surgery is surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. **Reconstructive Surgery** is surgery that is Medically Necessary and appropriate surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or create a normal appearance, to the extent possible.

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

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

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

Creditable Coverage

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

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

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

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

Deductible means the amount of charges you must pay for any Covered Services before any benefits are available to you under this Policy. Your Deductible is stated in the PART entitled COMPREHENSIVE BENEFITS: WHAT IS COVERED.

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

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

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

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

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

Domestic Partner meets the plan's eligibility requirements for Domestic Partners outlined in the section Who is Eligible for Coverage under the PART entitled ELIGIBILITY.

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

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

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

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

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

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

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

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

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

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

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

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

- permanently placing the Insured's health in jeopardy or
- causing other serious medical or psychiatric consequences or
- causing serious impairment to bodily functions or
- causing serious and permanent dysfunction of any bodily organ or part.

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

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

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

Mental or Nervous Disorders and Substance Abuse are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A Mental or Nervous Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental or Nervous Disorders are: schizophrenia, manic depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol or other substance addiction or abuse; depressive phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Any condition meeting this definition is a Mental or Nervous Disorder no matter what the cause. One or more of these conditions may be specifically excluded in this Policy. **However, medical services provided to treat medical conditions that are caused by behavior of the Insured that may be associated with these mental conditions (for example self-inflicted injuries) and treatment for Severe Mental Illnesses and Serious Emotional Disturbances of a Child are not subject to these limitations.**

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

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

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

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

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

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

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

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

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

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

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

Physician means:

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

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

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

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

Preferred Participating Hospital is a Hospital that has entered into a Preferred Participating Agreement with Anthem. A list of Preferred Participating Hospitals is available upon request from our customer service representatives.

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

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

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

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

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

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

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

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

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

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

PART XV MONTHLY PREMIUMS

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

There are different billing options available:

Paper Bill:
- Quarterly (3 months)
- Bi-Monthly (2 months)

Checking Account Deduction Program/Credit Card
- Monthly (1 month)

Note: An administrative fee of $2.00 may be added for a paper bill or credit card.

You will be responsible for an additional $25 charge for any check which is returned or dishonored by the bank as non-payable to Anthem for any reason.

Important: If you are enrolled in the checking account deduction program, your must give us thirty (30) days advance written notice to:
- Change banks
- Change account numbers
- Change account names
- Stop deduction
- Re-start eligible deductions

Electronic Funds Transfer: If you receive billing statements by mail and you submit a personal check for premium payments, you automatically authorize Anthem to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

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

Premiums are based upon Attained Age. If you are enrolled under a two (2) party or family coverage, the premiums will be based upon either the age of the Policyholder or the spouse, whichever is younger. We will recalculate your age for each billing and your premium will be automatically adjusted to the new rate.

Premiums are established for a specific regional area within which the Policyholder resides. If the Policyholder changes residence, he or she may be subject to a change in premiums. Such change in premiums will be effective on the next billing date following written notification of the change of residence. If the Policyholder does not notify us and we later learn of the change in residential address, at our option, we may bill for the difference in premium from the date the address changed.

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

We reserve the right to change the premiums on thirty (30) days written notice to the Policyholder prior to the close of any billing term. The change will become effective on the date shown in the notice and payment of the new charges will indicate acceptance of the change.

Please be sure to read the PART entitled TERMS OF YOUR POLICY for additional terms and conditions.

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

PART XVI ACCIDENTAL DEATH AND DISMEMBERMENT

This coverage pays benefits for loss of the Policyholder's life, sight, hand or foot caused by Accidental Injury. The amount payable depends on the type of loss. The maximum benefit that will be paid for all losses resulting from injuries sustained by the Policyholder in any one accident is $1,000.00.

BENEFITS

Benefits will be paid if a Policyholder sustains any of the losses listed in the Table of Losses if the loss:

- Results from an Accidental Injury which occurred while the Policyholder is insured,
- Is independent of all other causes and
- Occurs within ninety (90) days of the accident.

TABLE OF LOSSES

For the loss of:	The amount of payment will be:
Life Both hands or both feet Sight of both eyes One hand and one foot One hand and sight of one eye One foot and sight of one eye	The Maximum Benefit
One hand One foot Sight of one eye	One half the Maximum Benefit
Thumb and Index finger of either hand	One fourth the Maximum Benefit

With respect to the hands or feet, "loss" means actual severance at or above wrist or ankle joints. With respect to the eyes, "loss" means permanent and total loss of sight. With respect to thumbs and index fingers, "loss" means actual severance of entire digit at or above joints.

In any event, the maximum benefit will be paid only once for any one accident, no matter how many of the above listed losses occur as a result of that accident.

The maximum benefit will be reduced by 50% when the Policyholder reaches 65 years of age.

PROVISIONS

Eligibility: A person shall become eligible for insurance under this Policy with the purchase of the Anthem Life and Health Insurance Company (Anthem) PPO Basic Policy. The benefits are only available for the Policyholder but not the Insured Dependents.

Termination: The Accidental Death and Dismemberment insurance shall cease when the medical Policy purchased in conjunction with this Policy ends.

Beneficiary: Benefits will be paid to the Beneficiary named by the Policyholder. The name of the Beneficiary must be filed with Anthem.

- If two (2) or more Beneficiaries are named and if the Policyholder did not state otherwise, they will share equally. If any such Beneficiary should die before the Policyholder does, the share will pass to the surviving Beneficiary.
- If the Policyholder fails to name a Beneficiary for all or part of the insurance or if no Beneficiary survives the Policyholder, payment will be made in the following order:
  - the Policyholder's spouse, if living or
  - the Policyholder's then living children, equally or
  - the Policyholder's surviving parents, equally or
  - the Policyholder's estate.

Change of Beneficiary: The Policyholder may change the Beneficiary at any time by filing such change with Anthem. Any payment made by Anthem before its receipt of notice of such changes will fully discharge Anthem's obligation for such payment. The right of Change of Beneficiary is reserved for the Policyholder and the consent of the Beneficiary or Beneficiaries shall not be requisite to the surrender or assignment of this Policy, to any Change of Beneficiary or Beneficiaries or to any other changes in this Policy.

Assignment: An absolute Assignment by the Policyholder of all incidents of ownership of his/her Accidental Death and Dismemberment insurance will be permitted but only if Anthem is given notice of the Assignment. Anthem assumes no liability for the validity of any Assignment and may rely solely on the assignee's statement. Any such Assignment will only take effect for Anthem on the date it is received.

Amendments: The Policy may be amended or changed at any time by Anthem. Only an Officer of Anthem may change, amend, alter or waive in any manner the provisions of the Policy, and then only in writing and signed by the Officer. Anthem will not be bound by any promise made by any agent or person other than an Officer of Anthem.

Method of Settlement: Payment of insurance benefits will be made in one lump sum.

Notice and Proof of Claim: Written notice of claim must be given to Anthem within twenty (20) days after the occurrence or commencement of any loss covered by the Policy or as soon thereafter as is reasonably possible. Notice given by or on behalf or the Policyholder or the Beneficiary to Anthem Blue Cross Life and Health Insurance Company at 21555 Oxnard Street, Woodland Hills, California 91367 or to any authorized agent of Anthem, with information sufficient to identify the Policyholder, shall be deemed notice to Anthem.

Claim Forms: When Anthem receives notice of claim, forms for filing proof of claim will be furnished to the Beneficiary. If Anthem does not furnish the forms within fifteen (15) days from the time the notice is received by Anthem, the Beneficiary will have met the proof of loss requirement if written proof of loss is submitted within the time required.

Legal Action: No lawsuit or action may be brought to recover on the Policy within sixty (60) days after written proof of loss has been given. No lawsuit or action may be brought after three (3) years from the time written proof of loss is required to be given.

Examination: Anthem, at its own expense, will have the right to have a Policyholder examined as often as it may require whenever his/her loss is the basis of claim.

EXCLUSIONS

Workers' Compensation: No benefits will be paid for any loss for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employers' liability law or occupational disease law, even if you do not claim those benefits.

No benefits will be paid for any loss that is caused by:

a. All hernias
b. Disease or disorder of the body or mind or medical or surgical treatment thereof
c. Suicide or attempted suicide, while sane or insane
d. Self inflicted injury
e. War or any act of war whether or not declared
f. Commission of a felony or being engaged in an illegal occupation

Please contact customer service at 1-800-333-0912 to change the Beneficiary or Assignment, notify Anthem of a loss or ask any questions regarding your Policy.