Combined Evidence of Coverage and Disclosure Form

Anthem Bronze 60 D Health Savings Account PPO
1X5D

A Tiered Preferred Provider Organization (PPO) Plan

How to Get Language Assistance
Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our customer service call centers. Simply call the customer service phone number on the back of Your identification card and a representative will be able to help You. Translation of written materials about Your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing **711**. A special operator will get in touch with us to help with Your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the customer service number.)

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

Oral interpretation services are available in additional languages.

Anthem Blue Cross
P.O. Box 9051
Oxnard, CA 93031-9051
1-855-383-7247

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SUMMARY OF BENEFITS

Anthem Bronze 60 D Health Savings Account PPO
1X5D

A Tiered Preferred Provider Organization (PPO) Plan

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

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

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

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

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

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

Medical and Prescription Drug Deductible	**In Network You Pay**	**Out of Network You Pay**
Individual Plan	$4,500 per Benefit Period	$9,000 per Benefit Period
Family Plan	$9,000 per Benefit Period	$18,000 per Benefit Period

For each Benefit Period You must first satisfy the applicable In Network Medical and Prescription Drug Deductible and a separate Out of Network Medical and Prescription Drug Deductible for Covered Services. If the Plan covers only one (1) individual Member, the Member must satisfy the individual Deductible before we begin to pay for Covered Services. If a Plan covers two (2) or more Members, we will pay for Covered Services for an individual Member that has satisfied the individual Deductible. Once the Family Deductible is satisfied, we will pay for Covered Services for all other Members of the family. All Deductible amounts paid for Covered Services by each individual Member in a family during a Benefit Period contribute to the Family Deductible.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period will apply towards Your Medical and Prescription Drug Deductible, as applicable. Your In Network Medical and Prescription Drug Deductible for Covered Services will apply towards Your In Network Out of Pocket Maximum. Your Out of Network Medical and Prescription Drug Deductible for Covered Services will apply towards Your Out of Network Out of Pocket Maximum.

See "Deductibles" under YOUR PAYMENT RESPONSIBILITY for a detailed description of how Your Deductible works.

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

Out of Pocket Maximums	**In Network You Pay**	**Out of Network You Pay**
Individual Plan	$6,500 per Benefit Period	$13,500 per Benefit Period
Family Plan	$13,000 per Benefit Period	$27,000 per Benefit Period

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

Once the applicable Out of Pocket Maximum is satisfied, You will not have to pay any additional Deductibles, Copayments or Coinsurance for the rest of the Benefit Period. If the Plan covers only one (1) individual Member, the Member will have no further Copayments or Coinsurance after the applicable individual Out of Pocket Maximum is satisfied. If a Plan covers two (2) or more Member, an individual Member will have no further Copayments or Coinsurance once they have satisfied the applicable individual Out of Pocket Maximum. Once the applicable Family Out of Pocket Maximum is satisfied, all other Members of the family will not be subject to further Copayments or Coinsurance for the Benefit Period. All Deductibles, Copayments and Coinsurance amounts paid for Covered Services by each individual Member in a family during a Benefit Period contribute to the applicable Out of Pocket Maximum.

Unless stated otherwise, all amounts You pay for Covered Services during a Benefit Period for Deductibles, Coinsurance or Copayments apply to the Out of Pocket Maximum.

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

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

Cost Shares paid for Out of Network Emergency Care, including Emergency medical transportation (ambulance) and Emergency Hospital care, will apply to the In Network Out of Pocket Maximum.

See "Out of Pocket Maximums" under YOUR PAYMENT RESPONSIBILITY for a detailed description of how Your Out of Pocket Maximums work.

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

SUMMARY OF BENEFITS

COINSURANCE AND COPAYMENTS

The following lists the Coinsurance and Copayments for benefits under this Agreement. The following does not list all services or the locations where a service may be received. If a service is available in another setting, You may determine the applicable Cost Share by referring to that setting. For example, You might get Physical Therapy in a Physician's office, an outpatient Facility or during an inpatient Hospital stay. For services involving Behavioral Health Treatment for Pervasive Developmental Disorder or Autism, Mental Health or Substance Abuse look up "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" or "Mental Health and Substance Abuse (Chemical Dependency) Services." For services in the office, look up "Office Visits." For services in the outpatient department of a Hospital, look up "Outpatient Surgery Services." For services during an inpatient stay, look up "Inpatient Services."

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

Some services listed below require Precertification prior to receiving the service. See GETTING APPROVAL FOR BENEFITS for more information.

IMPORTANT: There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (e.g., Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at 1-855-383-7247. Providers other than Hospitals are not tiered. You are responsible for confirming that the Hospital where You are obtaining services or have been referred to is a Preferred In Network (Tier 1) Hospital or an In Network Provider for this Plan.

Anthem can help You find a Preferred In Network (Tier 1) Hospital or In Network Provider specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In Network Provider for this Plan. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers to provide services under this Plan. Any claims incurred with an Anthem contracted Provider who is not an In Network Provider under this Plan will be paid at the Out of Network level of benefits, even if You have been referred by another Anthem contracted Provider.

Anthem can help You find an In Network Provider specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.

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

SUMMARY OF BENEFITS

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Acupuncture	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Ambulance Services (Air, Ground and Water) • Precertification is required for ambulance services except in a Medical Emergency (see GETTING APPROVAL FOR BENEFITS for details) • Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out of Network Provider is used		
Ambulance Services	40% Coinsurance	Emergency: 40% Coinsurance plus all charges in excess of the Reasonable and Customary Value Non-Emergency: 60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism • Precertification is required for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism services (see GETTING APPROVAL FOR BENEFITS for details)		
Please Note: There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (*e.g.*, Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at **1-855-383-7247**. Providers other than Hospitals are not tiered. **You are responsible for confirming that the Hospital You are seeing or have been referred to see is a Preferred In Network (Tier 1) Hospital. Anthem can help You find a Preferred In Network (Tier 1) Hospital or an In Network (e.g., Physician) that can access a Preferred In Network (Tier 1) Hospital specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.**		

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

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Outpatient Office Visits	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other Outpatient Items and Services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preferred In Network (Tier 1) Hospital	**In Network**	
Inpatient services	40% Coinsurance	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	40% Coinsurance	
In Network (Tier 2) Hospital	**In Network**	
Inpatient services	50% Coinsurance	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	40% Coinsurance	
Out of Network Hospital	**Out of Network**	
Inpatient services	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Dental – Child Dental Services • Members are covered until the last day of the month in which they turn nineteen (19) years of age • See "Dental Services – Child" under WHAT IS COVERED – MEDICAL for benefit limits and frequencies		
Diagnostic and Preventive Services	No charge Not subject to the Deductible	0% Coinsurance plus all charges in excess of the Maximum Allowed Amount Coinsurance is not subject to the Deductible

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Basic Dental Services	20% Coinsurance Coinsurance is not subject to the Deductible	20% Coinsurance plus all charges in excess of the Maximum Allowed Amount Coinsurance is not subject to the Deductible
Major Dental Services	50% Coinsurance Coinsurance is not subject to the Deductible	50% Coinsurance plus all charges in excess of the Maximum Allowed Amount Coinsurance is not subject to the Deductible
Medically Necessary Orthodontic Care	50% Coinsurance Coinsurance is not subject to the Deductible	50% Coinsurance plus all charges in excess of the Maximum Allowed Amount Coinsurance is not subject to the Deductible
Diagnostic Testing • Precertification is required for certain diagnostic procedures and tests (see GETTING APPROVAL FOR BENEFITS for details) • If You receive diagnostic testing, the Cost Share for those services are in addition to the applicable Office Visit (PCP or SCP), outpatient surgery services or Urgent Care Coinsurance or Copayments		
Diagnostic laboratory and pathology services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Diagnostic imaging services and electronic diagnostic tests	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Advanced imaging services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies • Precertification is required for certain prosthesis and assistive devices (see GETTING APPROVAL FOR BENEFITS for details)	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Emergency Care (Emergency Room)		
Emergency room Facility charge	40% Coinsurance Coinsurance is waived if admitted into the Hospital from the Emergency room	40% Coinsurance Coinsurance is waived if admitted into the Hospital from the Emergency room
Emergency room Physician charge	40% Coinsurance Coinsurance is waived if admitted into the Hospital from the Emergency room	40% Coinsurance Coinsurance is waived if admitted into the Hospital from the Emergency room
Home Care Services • Precertification is required for home care services (see GETTING APPROVAL FOR BENEFITS for details) • Out of Network home care services are limited to one-hundred (100) visits per Benefit Period		
Home Care Services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Hospice Care • Precertification is required for Hospice Care (see GETTING APPROVAL FOR BENEFITS for details)	0% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Inpatient Services • Precertification is required for inpatient services (see GETTING APPROVAL FOR BENEFITS for details) • Precertification is **not** required for Emergency admissions and inpatient stays for the delivery of a child or mastectomy surgery, including the length of stays associated with mastectomy and/or breast reconstruction surgery for breast cancer • For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time (see GETTING APPROVAL FOR BENEFITS for details)		
Please Note: There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (e.g., Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at **1-855-383-7247**. Providers other than Hospitals are not tiered. **You are responsible for confirming that the Hospital You are seeing or have been referred to see is a Preferred In Network (Tier 1) Hospital. Anthem can help You find a Preferred In Network (Tier 1) Hospital or an In Network (e.g., Physician) that can access a Preferred In Network (Tier 1) Hospital specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.**		
Preferred In Network (Tier 1) Hospital	**In Network**	
Inpatient Hospital fee	40% Coinsurance	
Physician/Surgeon fee	40% Coinsurance	
In Network (Tier 2) Hospital	**In Network**	
Inpatient Hospital fee	50% Coinsurance	
Physician/Surgeon fee	40% Coinsurance	
Out of Network Hospital	**Out of Network**	
Inpatient Hospital fee	Emergency: 50% Coinsurance Non-Emergency: 60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	

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

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Physician/Surgeon fee	Emergency: 40% Coinsurance Non-Emergency: 60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Facilities other than a Hospital (including Residential Treatment Centers)	**In Network**	**Out of Network**
Inpatient Hospital fee	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physician/Surgeon fee	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Maternity Care		
Please Note: There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (e.g., Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at **1-855-383-7247**. Providers other than Hospitals are not tiered. **You are responsible for confirming that the Hospital You are seeing or have been referred to see is a Preferred In Network (Tier 1) Hospital. Anthem can help You find a Preferred In Network (Tier 1) Hospital or an In Network (e.g., Physician) that can access a Preferred In Network (Tier 1) Hospital specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.**		
Preconception and prenatal care	No charge Not subject to the Deductible	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Postnatal care	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preferred In Network (Tier 1) Hospital	**In Network**	

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

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Inpatient Hospital fee	40% Coinsurance	
Delivery and inpatient professional fee	40% Coinsurance	
In Network (Tier 2) Hospital	**In Network**	
Inpatient Hospital fee	50% Coinsurance	
Delivery and inpatient professional fee	40% Coinsurance	
Out of Network Hospital	**Out of Network**	
Inpatient Hospital fee	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Delivery and inpatient professional fee	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Mental Health and Substance Abuse (Chemical Dependency) Services • Precertification is required for certain Mental Health and Substance Abuse services except in an Emergency (see GETTING APPROVAL FOR BENEFITS for details)		
Please Note: There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (*e.g.*, Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at **1-855-383-7247**. Providers other than Hospitals are not tiered. **You are responsible for confirming that the Hospital You are seeing or have been referred to see is a Preferred In Network (Tier 1) Hospital. Anthem can help You find a Preferred In Network (Tier 1) Hospital or an In Network (e.g., Physician) that can access a Preferred In Network (Tier 1) Hospital specific to Your Plan by calling customer service at 1-855-383-7247 or access our website at www.anthem.com/ca.**		
Outpatient Office Visits	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other Outpatient Items and Services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preferred In Network (Tier 1) Hospital	**In Network**	

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

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Inpatient services	40% Coinsurance	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	40% Coinsurance	
In Network (Tier 2) Hospital	**In Network**	
Inpatient services	50% Coinsurance	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	40% Coinsurance	
Out of Network Hospital	**Out of Network**	
Inpatient services	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Inpatient Physician/Surgeon fee (when billed separately from the inpatient services)	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount	
Office Visits • Additional services received during an Office Visit may be subject to additional Coinsurance or Copayments • For Preventive Care visits, please see Preventive Care below		
Primary Care Physician and Primary Care Provider (PCP)	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Specialty Care Physician (SCP)	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other practitioner Office Visit	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Retail health clinic visit	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Online care visit	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Telehealth	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Other Eligible Providers If You obtain services from Other Eligible Providers, Your responsibility will be 40% Coinsurance **plus** all charges in excess of the Maximum Allowed Amount		
Outpatient Surgery Services • Precertification is required for surgical procedures (see GETTING APPROVAL FOR BENEFITS for details) • Additional services received in an outpatient surgery Hospital or Facility may be subject to additional Coinsurance or Copayments		
Outpatient Hospital or Facility fee	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Ambulatory Surgical Center	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient visit	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Physician/Surgeon fee	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Outpatient Habilitation Services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Outpatient Rehabilitation Services	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Preventive Care	No charge Not subject to the Deductible	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Skilled Nursing Facility • Precertification is required for a Skilled Nursing Facility (see GETTING APPROVAL FOR BENEFITS for details)		
• Out of Network Skilled Nursing Facility is limited to one-hundred (100) days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A Skilled Nursing Day Allowance ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends. This limit does not apply to Mental Health and Substance Abuse Services or Behavioral Health Treatment		
Skilled Nursing care	40% Coinsurance	60% Coinsurance plus all charges in excess of the Maximum Allowed Amount
Urgent Care • Additional services received in an Urgent Care may be subject to additional Coinsurance or Copayments		
Urgent Care	40% Coinsurance	40% Coinsurance
Vision – Child Vision Services • Members are covered until the last day of the month in which they turn nineteen (19) years of age • To get the In Network benefit You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please visit our website or call us at the number on Your ID card		

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

Benefit	You Pay Coinsurance / Copayment In Network	 Out of Network
Routine Eye Exam Once every Benefit Period	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Comprehensive Low Vision Exam Once every five (5) Benefit Periods	No charge Not subject to the Deductible	Not covered
Optical/Non-Optical Aids and Supplemental Testing Limited to one (1) occurrence of either optical/non-optical aids or supplemental testing per Benefit Period	No charge Not subject to the Deductible	Not covered
Standard Plastic or Glass Lenses* • Once every Benefit Period • Factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses are covered at no additional cost when received from an In Network Provider		
Single Vision	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Bifocal	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Trifocal	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible

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

Benefit	You Pay Coinsurance / Copayment In Network	Out of Network
Progressive	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Frames* (formulary) • Once every Benefit Period • This Agreement offers a selection of covered frames	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Contact Lenses (formulary)* • A one (1) Year supply is covered every Benefit Period (applicable to certain contact lenses within the formulary) • Contact lenses for Aniridia will be covered up to two (2) contact lenses per eye (including fitting and dispensing) per Benefit Period • Contact lenses for Aphakia will be covered up to six (6) contact lenses per eye (including fitting and dispensing) per Benefit Period • This Agreement offers a selection of covered contact lenses • Except as stated above for Aniridia and Aphakia, fitting and evaluation of contact lenses is not a covered benefit and will be an additional cost to the Member		
Elective (conventional and disposable) These are contact lenses chosen for comfort or appearance	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
Non-elective These are contact lenses that are prescribed to You for a medical condition	No charge Not subject to the Deductible	$0 Copayment plus all charges in excess of the Maximum Allowed Amount Copayment is not subject to the Deductible
*If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in this SUMMARY OF BENEFITS		

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

SUMMARY OF BENEFITS

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

PRESCRIPTION DRUG BENEFITS
Prescription Drug benefits accumulate toward the applicable Out of Pocket Maximum.
You must pay the applicable Deductible before Your benefits begin.

Anthem uses a Select Drug List (Formulary) or list of Drugs that includes a select number of medications in therapeutic categories and classes.

Each Prescription Drug will be subject to a Copayment/Coinsurance as described below. If Your Prescription Drug order includes more than one Prescription Drug, a separate Copayment/Coinsurance will apply to each Prescription Drug.

Note: Oral chemotherapy drugs are subject to a maximum Copayment or Coinsurance not to exceed $200 for a thirty (30) day supply after Your Deductible for the Benefit Period is satisfied.

IMPORTANT NOTE:
Benefits for Covered Services are based on the Prescription Drug Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. When You use an Out of Network Provider, You may have to pay the difference between the Out of Network Provider's billed charge and the Prescription Drug Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles and non-covered charges. This amount can be substantial. Please read YOUR PAYMENT RESPONSIBILITY and WHAT IS COVERED – PRESCRIPTION DRUGS for more details.

See WHAT IS COVERED – PRESCRIPTION DRUGS and WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for descriptions of Covered Services, limitations and exclusions. In cases where Your Physician prescribes a medication that is not on the Anthem Select Drug List (Formulary), it may be necessary to obtain Prior Authorization in order for the Prescription to be a covered benefit. Physicians and Members are informed of the Prior Authorization process through the Subscriber's Agreement, Anthem's web site, www.anthem.com/ca and the Provider's manual.

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

Benefit	Coinsurance / Copayment	
	In Network You Pay	Out of Network You Pay
Prescription Drug Deductible (retail & home delivery combined)		
Individual Plan	In Network Prescription Drugs are subject to the same In Network Deductible as Your Medical Benefits	Out of Network Prescription Drugs are subject to the same Out of Network Deductible as Your Medical Benefits
Family Plan	In Network Prescription Drugs are subject to the same In Network Deductible as Your Medical Benefits	Out of Network Prescription Drugs are subject to the same Out of Network Deductible as Your Medical Benefits
Retail Prescription – 30 day supply		
Tier 1	40% Coinsurance	60% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 2	40% Coinsurance	60% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 3	40% Coinsurance	60% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount
Tier 4	40% Coinsurance	60% Coinsurance plus all charges in excess of the Prescription Drug Maximum Allowed Amount

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

Benefit	Coinsurance / Copayment	
	In Network You Pay	Out of Network You Pay
Home Delivery (Mail Order) Prescription – 90 day supply • Specialty Drugs are limited to a 30 day supply		
Tier 1	40% Coinsurance	Not covered
Tier 2	40% Coinsurance	Not covered
Tier 3	40% Coinsurance	Not covered
Tier 4	40% Coinsurance	Not covered

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

1X5D
Anthem Bronze 60 D Health Savings Account PPO

INTRODUCTION

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

In this Agreement, "we," "us," "our" and "Anthem" shall mean Anthem Blue Cross. You are the eligible Subscriber whose individual enrollment application has been accepted by us. "You" and "Your" also mean any eligible Dependents who are covered under this Agreement. When we use the word "Member" in this Agreement, we mean You and any eligible Dependents who are covered under this Agreement.

THIS AGREEMENT IS ONLY OFFERED AND ISSUED IN CERTAIN GEOGRAPHIC AREAS WITHIN THE STATE OF CALIFORNIA. IF YOU CHANGE YOUR RESIDENCE TO A LOCATION THAT IS OUTSIDE OF THE SERVICE AREA, BUT YOU CONTINUE TO RESIDE IN THE STATE OF CALIFORNIA, CONTACT ANTHEM TO ENROLL IN A DIFFERENT INDIVIDUAL HEALTH BENEFIT PLAN.

Coverage under this Plan does not establish a Healthcare Savings Account (HSA). You must open an HSA with a financial institution qualified under applicable federal law and Internal Revenue Service rules. If You intend to purchase this Plan to use with an HSA for tax purposes, You should seek professional guidance from an attorney, accountant or other qualified advisor.

IF THIS AGREEMENT IS PROVIDED TO YOU AS A NEW SUBSCRIBER, YOU HAVE THE RIGHT TO VIEW THE AGREEMENT PRIOR TO ENROLLMENT.

IF THIS AGREEMENT IS PROVIDED TO YOU AS A NEW SUBSCRIBER, ONCE ENROLLED, YOU HAVE THIRTY (30) DAYS FROM THE DATE OF DELIVERY TO EXAMINE THIS AGREEMENT. IF YOU ARE NOT

SATISFIED, FOR ANY REASON WITH THE TERMS OF THIS AGREEMENT, YOU MAY RETURN THE AGREEMENT TO US WITHIN THOSE THIRTY (30) DAYS. YOU, CONSISTENT WITH CALIFORNIA LAW, WILL BE REQUIRED TO PAY FOR ANY SERVICES ANTHEM BLUE CROSS PAID ON YOUR BEHALF DURING THE THIRTY (30) DAY PERIOD AND ANTHEM BLUE CROSS WILL REFUND ANY PREMIUM PAID BY YOU, LESS YOUR MEDICAL AND PHARMACY EXPENSES THAT ANTHEM BLUE CROSS PAID. IF NO SERVICES WERE RENDERED, YOU WILL BE ENTITLED TO RECEIVE A FULL REFUND OF ANY PREMIUMS PAID. THIS AGREEMENT WILL THEN BE NULL AND VOID.

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

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

The Subscriber hereby expressly acknowledges its understanding that this Agreement constitutes a contract solely between the Subscriber and Anthem Blue Cross, 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, (the "Association") permitting Anthem Blue Cross to use the Blue Cross Service Mark in the State of California, and that Anthem Blue Cross is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Anthem Blue Cross and that no person, entity, or organization other than Anthem Blue Cross shall be held accountable or liable to the Subscriber for any of Anthem Blue Cross's obligations to the Subscriber created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Blue Cross other than those obligations created under other provisions of this Agreement.

INTRODUCTION

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

Choice of Preferred In Network Hospital, In Network Provider or Out of Network Provider

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

Preferred In Network Hospitals and In Network Hospitals

There are two types of In Network Hospitals - Preferred In Network (Tier 1) Hospitals and In Network (Tier 2) Hospitals. Your financial responsibility for Covered Services will be less when You obtain services from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. Not all In Network Providers (e.g., Physicians) can access or are able to provide services through In Network (Tier 2) Hospitals. In order to determine if an In Network Provider can access or provide service through a Preferred In Network (Tier 1) or an In Network (Tier 2) Hospital, call customer service at 1-855-383-7247. Providers other than Hospitals are not tiered. For assistance locating a Preferred In Network (Tier 1) Hospital) or an In Network Provider (other than Hospitals), You may contact us at 1-855-383-7247 or access our website at www.anthem.com/ca.

In Network versus Out of Network

You have the right to choose an In Network Provider or Out of Network Provider (e.g. a Physician or Hospital). To maximize Your benefits, be sure to confirm that the Provider (e.g. a Physician or Hospital) You wish to see is an In Network Provider under Your Plan see "Your Network of Providers" below in this part). Claims paid at the Out of Network level of benefits may mean a higher financial responsibility for You. It is important to understand that Anthem has many contracting Providers who may not be part of Your Plan's network of Providers. For example, You may be treated for a non-Emergency Service in a Hospital. If the anesthesiologist or radiologist does not participate in Your specific network of Providers under Your Anthem Plan, any claims incurred will be paid at the Out of Network level of benefits to the extent Your Plan includes Out of Network benefits.

Your Network of Providers

Providers that have a contract with Anthem agree to provide Covered Services to Anthem Members enrolled under specific but not all health benefit plans offered by Anthem. This means a Provider may have a contract with Anthem but is not contracted to provide Covered Services under this Plan. It is important to understand that only Providers that are contracted to provide Covered Services for this Plan are considered an In Network Provider.

Information about Your Network can be found in the APPENDIX II – SUBSCRIBER AND PREMIUM INFORMATION, by calling customer service at 1-855-383-7247 or on our website www.anthem.com/ca.

How to Find a Provider in the Network

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

- See our directory of In Network Providers at **www.anthem.com/ca**, which lists the Physicians, Providers and Facilities that participate in our network. Dental services in this Plan (see "Dental Services – Child" under WHAT IS COVERED – MEDICAL) are provided by dental Providers that have agreed to service our Dental standard: Prime program. To find participating dental Providers, visit our website at **www.anthem.com/ca** and under 'Plan Type' select "Dental Plans" and Dental standard: Prime as the Plan Name.
- Call customer service at **1-855-383-7247** or access our website at **www.anthem.com/ca** for a list of Physicians, Providers and Facilities that participate in our network, based on specialty and geographic area.
- Check with Your Physician or Provider.

If You need details about a Provider's license or training, or help choosing a Physician who is right for You, call the customer service number at **1-855-383-7247** or the number on the back of Your identification card. TTY/TDD services also are available by dialing **711**. A special operator will get in touch with us to help with Your needs.

Note: We have several Provider networks, and a Provider that is In Network for one Plan may not be In Network for another. Information about Your Network can be found in the APPENDIX II – SUBSCRIBER AND PREMIUM INFORMATION, by calling customer service at **1-855-383-7247** or on our website **www.anthem.com/ca**.

To see a Physician, call their office:

- Tell them You are an Anthem Member.
- Have Your identification card handy. The Physician's office may ask You for Your group or ID number.
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your identification card with You.

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under Your Plan contract and that You or Your family member might need: family planning; contraceptive services, including Emergency contraception; sterilization, including tubal ligation at the time of labor and delivery infertility treatments or abortion. You should obtain more information before You enroll. Call Your prospective doctor, Medical Group, independent practice association, or clinic or call the health plan at 1-855-383-7247 to ensure that You can obtain the health care services that You need.

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

You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling our customer service department at 1-855-383-7247 or by accessing our website at www.anthem.com/ca.

Triage or Screening Services

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

RIGHT TO MODIFY OR CHANGE THE AGREEMENT

Anthem has the right to and may modify or otherwise change the terms, benefits, and conditions of the Agreement, including without limitation, Premiums, covered benefits, Deductibles, Copayments or Coinsurance, as set forth herein. Anthem must provide at least sixty (60) days written notice of any such modifications or changes. The right to modify Your Agreement on sixty (60) day notice is not affected by the use of calendar Year or annual time periods to measure or determine Deductibles or maximum Copayments or Coinsurance.

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

YOUR ELIGIBILITY

This Agreement is only offered and issued in certain geographic areas within the State of California. If You change Your residence to a location that is outside of the Service Area, but You continue to reside in the State of California, contact Anthem to enroll in a different Individual health benefit plan.

Who is Eligible for Coverage

Subscriber

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

1. Reside in the Service Area;
2. Agree to pay for the cost of Premium that Anthem requires;
3. Not be incarcerated (except pending disposition of charges);
4. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D;
5. Not be covered by any other group or individual health benefit plan.

Dependents

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

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

Children over the age of 26 may be eligible for coverage as a Dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the Subscriber for support and maintenance. To qualify as an overage Dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage. Eligibility will be continued past the age limit of twenty-six (26) as an Overage Dependent only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability.

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

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

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

Newborn and Adopted Child Coverage

Newborn and Adopted Child(ren) of the Subscriber or the Subscriber's spouse will be covered for an initial period of thirty-one (31) days from the date of birth or adoption. Coverage for Newborn and Adopted Child(ren) will continue beyond the thirty-one (31) days, provided the Subscriber submits a form to us or calls customer service at **1-855-383-7247** to add the child under the Subscriber's Plan. The form must be submitted along with the additional Premium, if applicable, within sixty (60) days after the birth of the child. Failure to notify us and pay any applicable Premium during this sixty (60) day period will result in no coverage for the Newborn or Adopted Child beyond the first thirty-one (31) days.

A child will be considered adopted from the earlier of:

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

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

Newborn and Adopted Children of the Subscriber's, Subscriber's spouse's or Subscriber's Domestic Partner's Dependent children **are not** covered under this Agreement. (Unless they are eligible for coverage under another provision of this Agreement.)

Adding a Child due to Award of Guardianship

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

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

Individuals not eligible for Dependent coverage

- Spouses of Dependent children are not eligible for coverage under this Agreement.
- Children, including Newborns and Adopted Children, of Dependent children are not eligible for coverage under this Agreement unless that child meets other coverage criteria established under State law.
- Temporary custody is not sufficient to establish eligibility under this Agreement.

Qualified Medical Child Support Order

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

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

Notice to Subscribers Regarding Premium Charges and Right to Buy Coverage

After an enrollee submits a completed application form for the Agreement, Anthem will, within thirty (30) days, notify the individual of their actual premium charges for that Agreement. The individual shall have thirty (30) days in which to exercise the right to buy coverage at the quoted Premium charges.

Open Enrollment

An annual Open Enrollment period is provided for enrollees in compliance with state and federal requirements. Individuals may enroll in a health benefit plan and Members may change their health benefit plan at that time.

Effective Dates for annual Open Enrollment period:

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

Qualifying Events:

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

Effective Dates for Special Enrollment periods:

When the individual submits a Premium payment, based on the quoted Premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first fifteen (15) days of the month, coverage under the Agreement shall become effective no later than the first (1st) day of the following month. When the Premium payment is neither delivered nor postmarked until after the fifteenth (15th) day of the month, coverage shall become effective no later than the first (1st) day of the second (2nd) month following delivery or postmark of the payment.

Exceptions to Effective Dates for Special Enrollment periods:

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

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

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

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

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

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

Notice of Changes

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

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

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

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

Anthem Blue Cross

P.O. Box 9051

Oxnard, California 93031-9051

Statements and Forms

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

Delivery of Documents

We will provide an identification card and an Evidence of Coverage for each Subscriber.

Monthly Premiums

Premiums are due monthly and are the charges You must pay Anthem to establish and maintain coverage. We determine and establish the required Premiums based on the Subscriber's age, number of Members and the specific regional area in which the Subscriber resides.

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

Monthly Premiums can be found in the APPENDIX II – SUBSCRIBER AND PREMIUM INFORMATION and on Your monthly billing statement. All Monthly Premium Payments and administrative fees are payable in advance and due on the Monthly Premium Due Date.

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

Coverage under this Agreement will end if the Member moves out of the Service Area. You will be eligible for a Special Enrollment to change to the plans available in the new Service Area to which You have moved to in California. You will need to find a new In Network Provider in Your new Service Area.

How to pay Your Premium

After making Your initial Premium Payment, You can make Your Premium Payment online at **www.anthem.com/ca,** by contacting customer service at **1-855-383-7247** or by mailing it to us. For Your convenience, You may authorize us to automatically deduct Your Premium Payment from Your financial institution account every month. To learn more about this option, contact customer service.

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

Anthem Blue Cross

P.O. Box 51011

Los Angeles, California 90051-5311

Electronic Funds Transfer

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

Non-sufficient Funds

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

Termination

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

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

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

Effective Dates of Termination

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

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

- If You stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the Grace Period.

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

Guaranteed Renewable

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

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage, and;
3. Membership has not been terminated by Anthem under the terms of this Agreement.

Loss of Eligibility

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

Rescission

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

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

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

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

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

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

Eligibility following Rescission

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

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

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

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

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

Discontinuation of Health Coverage

We can refuse to renew Your Agreement if we decide to discontinue a health coverage product that we offer in the individual market. If we discontinue a health coverage product, we will provide You with at least ninety (90) days notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that we currently offer without regard to claims status or health history. Non-renewal will not affect an existing claim.

Reinstatement of Coverage for Members of the Military

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

After Termination

Once this Agreement is terminated, the former Members cannot reapply until the next annual Open Enrollment period unless they experience an event that qualifies for a Special Enrollment period prior to the annual Open Enrollment period.

Grace Period

This Agreement has a thirty (30) day Grace Period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next thirty (30) days. During the Grace Period, the Agreement will stay in force unless prior to the date Premium payment is due You give timely written notice to us that the Agreement is to be terminated. If You do not make the full Premium payment during the Grace Period, the Agreement will be terminated on the last day of the Grace Period. You will be liable to us for the Premium payment due including those for the Grace Period. You will also be liable to us for any claims payments made for services incurred after the Grace Period.

Removal of Members

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

Refunds of Premium

Upon Termination, we shall return promptly the unearned portion of any Premium paid.

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

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

You have the options of going to both Anthem and/or the Department of Managed Health Care.

- Option 1
  - You may submit a Request for Review to Anthem by calling customer service at **1-855-383-7247**, submitting a request at **www.anthem.com/ca** or by mailing Your written Request for Review to:

    Anthem Blue Cross

    P.O. Box 9051

    Oxnard, CA 93031-9051
  - You may want to submit Your Request for Review to Anthem first if You believe Your cancellation, termination, rescission or nonrenewal is the result of a mistake. Requests for Review should be submitted as soon as possible after You receive a Notice of Cancellation, Rescission or Nonrenewal.
  - Anthem will resolve Your Request for Review within three (3) days. If Anthem upholds Your cancellation, termination rescission or nonrenewal, it will immediately transmit Your Request for Review to the Department of Managed Health Care and You will be notified of the Plan's decision and Your right to also seek a further review of the Plan's decision by the Department of Managed Health care as detailed under Option 2, below.

- Option 2
  - You may submit a Request for Review directly to the Department of Managed Health Care.
  - You may submit a Request for Review directly to the Department of Managed Health Care without first submitting it to the Plan or after You have received the Plan's decision on Your Request for Review.

HOW YOUR COVERAGE WORKS

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

This is a Preferred Provider Organization (PPO) Plan. We provide access to a network of Hospitals and Providers who contract with Anthem to facilitate services to our Members and who provide services at pre-negotiated discounted rates. Benefits for In Network Providers are based on a Maximum Allowed Amount. In Network Providers have an agreement in effect with Anthem and have agreed to accept the Maximum Allowed Amount as payment in full. An In Network Provider may, after notice from us, be subject to a reduced Maximum Allowed Amount in the event the In Network Provider fails to make routine referrals to In Network Providers, except as otherwise allowed (such as for Medical Emergency Services). Out of Network Providers do not have an agreement with Anthem. Your personal financial costs when using Out of Network Providers may be considerably higher than when You use In Network Hospitals or In Network Providers. Further, for certain services there may be no benefit provided when using an Out of Network Provider. You will be responsible for any amount not paid by Anthem when using the services of an Out of Network Provider. Please read the SUMMARY OF BENEFITS and the benefit sections under WHAT IS COVERED – MEDICAL carefully to determine these differences. For assistance locating In Network Providers, You may contact us at **1-855-383-7247** or access our website at **www.anthem.com/ca**.

In Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians (SCPs)), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit an In Network Specialist including behavioral health Providers.

Maximum Allowed Amount

The Maximum Allowed Amount is the total reimbursement allowed under this Agreement for Covered Services You receive from In Network Providers, Out of Network Providers and Other Eligible Providers. It is our payment towards the services billed by Your Provider combined with any Deductible, Copayment or Coinsurance owed by You. In some cases, You may be required to pay the entire Maximum Allowed Amount. For instance, if You have not met Your Deductible under the Agreement, then You could be responsible for paying the entire Maximum Allowed Amount for Covered Services. In addition, if these services are received from an Out of Network Provider or Other Eligible Provider, You may be billed by the Provider for the difference between their charges and our Maximum Allowed Amount. In many situations, this difference could be significant.

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

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

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

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

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

Provider Status

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

In Network Providers: For Covered Services performed by an In Network Provider, the Maximum Allowed Amount for Your Agreement is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because In Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have a Deductible, Copayment, or Coinsurance.

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

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

Please see WHAT IS COVERED – MEDICAL for additional information.

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

Member Cost Share

For certain Covered Services, You may be required to pay all or a part of the Maximum Allowed Amount as Your Cost Share amount (Deductible, Copayment, and/or Coinsurance). Your Cost Share amount and Out of Pocket Maximums may be different depending on whether You received Covered Services from an In Network Provider, Out of Network Provider or Other Eligible Provider. Specifically, You may be required to pay higher cost-sharing amounts or may have limits on Your benefits when using Out of Network Providers or Other Eligible Providers. See the SUMMARY OF BENEFITS and WHAT IS COVERED – MEDICAL for Your Cost Share responsibilities and limitations, or call us at **1-855-383-7247** to learn how this Plan's benefits or Cost Share amounts may vary by the type of Provider You use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In Network Provider, Out of Network Provider or Other Eligible Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Plan including services received but are not Medically Necessary and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The responsibility for services that are denied because they are not Medically Necessary is dependent upon a Provider's status. Network Providers are prohibited by their contract with us from billing or collecting from You for any services that are provided but denied because they are not Medically Necessary unless they obtain a written agreement from You wherein You agree to pay for such services. Out of

Network Providers do not have a contract with us and You will be responsible for the total amount billed by an Out of Network Provider for services that are denied because they are not Medically Necessary.

In some instances, You may only be asked to pay the In Network Provider Cost Share percentage when You use an Out of Network Provider. For example, if You go to an In Network Hospital and receive Covered Services from an Out of Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the Hospital, You will pay the In Network Provider Cost Share percentage of the Maximum Allowed Amount for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out of Network Provider's charge.

Authorized Referrals

In some circumstances, we may authorize a Preferred In Network (Tier 1) Hospital or an In Network Provider Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an In Network Hospital (Tier 2) or an Out of Network Provider. In such circumstance, You or Your Physician must contact us in advance of obtaining the Covered Service. It is Your responsibility to ensure that we have been contacted. If we certify an Out of Network Provider at an In Network Provider Cost Share, You may also be responsible for the difference between the Out of Network Provider's charges and the Maximum Allowed Amount. If You receive Preauthorization for an Out of Network Provider due to network adequacy issues, You will not be responsible for the difference between the Provider's Out of Network charges and the Maximum Allowed Amount. Please contact us at **1-855-383-7247** for Authorized Referral information or to request authorization.

Important: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In Network Provider under Your Plan. It is important to understand that Anthem has many contracting Providers who may not be part of Your Plan's network of Providers. Any claims incurred with an Anthem contracted Provider who is not a part of Your Plan's In Network Providers, will be paid at the Out of Network level of benefits, even if You have been referred by another Anthem contracted Provider.

Anthem can help You find an In Network Provider specific to Your Plan by calling customer service at **1-855-383-7247**.

Reminder: Carry Your identification ("ID") card.

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

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

Inter-Plan Arrangements

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When You obtain Covered Services outside of Anthem's Service Area, the claims may be processed through one of these Inter-Plan Programs. These programs include the BlueCard® Program, described below. They may also include negotiated national account arrangements between Anthem and other Blue Cross and Blue Shield Licensees. Typically, when You access medical care outside Anthem's Service Area, You will obtain it from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, You may obtain care from non-participating Providers. Anthem's payment practices in both cases are generally described below.

BlueCard® Program

Under the BlueCard® Program, when You obtain Covered Services within the geographic area served by a Host Blue, Anthem still fulfill its contractual obligations. But the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

Whenever You obtain Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

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

Often, this "Negotiated Price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account a special arrangement with that Provider or Provider group. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve: types of settlements; incentive payments; and/or other credits or charges.

Estimated and average pricing arrangements going forward, also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the types of transactions noted above. But such adjustments will not affect the price on the claim that Anthem will use to determine the amount You pay.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any State law mandate other liability calculation methods, including a surcharge, Anthem calculates a Member's liability for any Covered Service according to applicable law.

Non-participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation

When You obtain Covered Services from non-participating health care Providers outside of Anthem's Service Area, the amount You pay for the services and supplies will generally be based on either: (a) the Host Blue's non-participating Provider local payment; or (b) the pricing arrangements required by applicable state law. In these cases, You may be responsible for the difference between: (a) the amount that the non-participating Provider bills; and (b) the payment Anthem makes for the Covered Services.

In some cases, Anthem may pay such claims differently than described above. For example, Anthem's payment for Covered Services obtained from non-participating Providers could be made based on: (a) billed Covered Charges; (b) the payment Anthem would make if the Covered Services had been obtained within its Service Area; or (c) a special negotiated payment, as allowed under Inter-Plan Program rules. In these cases, You may be liable for the difference between: (a) the amount that the non-participating healthcare Provider bills; and (b) the payment Anthem makes for the Covered Services.

Travel outside the United States – BlueCard Worldwide

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

When You are traveling abroad and need medical care

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

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

Refer to GETTING APPROVAL FOR BENEFITS. You can learn how to get Authorization when You need to be admitted to the Hospital for Emergency Care.

How claims are paid with BlueCard Worldwide

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

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

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

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

Additional information on BlueCard Worldwide claims:

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

When You need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

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

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

YOUR PAYMENT RESPONSIBILITY

Important: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In Network Provider under Your Plan. It is important to understand that Anthem has many contracting Providers who may not be part of Your Plan's network of Providers. Any claims incurred with an Anthem contracted Provider who is not a part of Your Plan's In Network Providers, will be paid at the Out of Network level of benefits, even if You have been referred by another Anthem contracted Provider.

Anthem can help You find an In Network Provider specific to Your Plan by calling customer service at **1-855-383-7247**.

Copayments and Coinsurance

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

Coinsurance is the percentage amount of the Maximum Allowed Amount that You are responsible for as stated in the SUMMARY OF BENEFITS.

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

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

After Your applicable Deductible has been satisfied, You will be required to pay Copayments and Coinsurance for Covered Services received while You are covered under this Plan.

Copayments and Coinsurance are required for Covered Services until the applicable Out of Pocket Maximum is reached for each Benefit Period. Once the applicable Out of Pocket Maximum is reached, You will not be required to pay any further Copayments or Coinsurance for Covered Services for the remainder of the Benefit Period.

Deductibles

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

Each Benefit Period, You must satisfy Your Deductibles before we will pay benefits for Covered Services. Your Deductibles may include an In Network Medical Deductible, an Out of Network Medical Deductible, an In Network Prescription Drug Deductible and an Out of Network Prescription Drug Deductible for Covered Services.

Your In Network Deductible is a combination of Your Deductible responsibility for Covered Services provided by In Network Providers for medical services and Your In Network responsibility for Covered Services provided by In Network Pharmacy Providers for Prescription Drugs. Your Out of Network Deductible is a combination of Your Deductible responsibility for Covered Services provided by Out of Network Providers for medical services and Your Deductible responsibility for Covered Services provided by Out of Network Pharmacy Providers for Prescription Drugs.

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

In Network Deductibles

Your In Network Deductible is a combination of Your Deductible responsibility for Covered Services provided by In Network Providers for medical services and Your Deductible responsibility for Covered Services provided by In Network Pharmacy Providers for Prescription Drugs. Before we will make payment for certain Covered Services, You must first satisfy the combined In Network Medical and Prescription Drug Deductible.

Your In Network Deductible amount is determined by the number of family members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the In Network Individual Deductible applies. If more than one (1) person is enrolled in this Plan, then both the In Network Individual Deductible and the In Network Family Deductible apply.

- **In Network Individual Deductible for one (1) Member**
  - Once the total allowable charges applying to the In Network Individual Deductible have been met, no further In Network Deductible for the Member will be required for the remainder of that Benefit Period.
- **In Network Family Deductible for two (2) or more Members**
  - Once the total allowable charges applying to the In Network Individual Deductible have been met for one (1) Member, no further In Network Deductible for the Member will be required for the remainder of that Benefit Period. The Member's In Network Individual Deductible will contribute towards the In Network Family Deductible.
  - All other family Members will be subject to the remainder of the In Network Family Deductible until the In Network Family Deductible is satisfied. All Deductible amounts paid for Covered Services by each individual Member in a family during a Benefit Period will contribute to the remainder of the family's Deductible.

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

Out of Network Deductibles

Your Out of Network Medical Deductible and Your Out of Network Prescription Drug Deductible are combined. Each Benefit Period, You must satisfy the combined Out of Network Medical and Prescription Drug Deductible.

Your Out of Network Deductible amount is determined by the number of family members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the Out of Network Individual Deductible applies. If more than one (1) person is enrolled in this Plan, then both the Out of Network Individual Deductible and the Out of Network Family Deductible apply.

- **Out of Network Individual Deductible for one (1) Member**
  - Once the total allowable charges applying to the Out of Network Individual Deductible have been met, no further Out of Network Deductible will be required for the remainder of that Benefit Period.
- **Out of Network Family Deductible for two (2) or more Members**
  - Once the total allowable charges applying to the Out of Network Individual Deductible have been met for one (1) Member, no further Out of Network Deductible for the Member will be required for the remainder of that Benefit Period. The Member's Out of Network Individual Deductible will contribute towards the Out of Network Family Deductible.

- All other family Members will be subject to the remainder of the Out of Network Family Deductible until the Out of Network Family Deductible is satisfied. All Deductible amounts paid for Covered Services by each individual Member in a family during a Benefit Period will contribute to the remainder of the family's Deductible.

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

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

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

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

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

Out of Pocket Maximums

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

The In Network and Out of Network Out of Pocket Maximums are separate and do not apply toward each other. Cost Shares paid for Out of Network Emergency Care, including Emergency medical transportation

(ambulance), Emergency Hospital care and services pre-authorized by Anthem will apply to the In Network Out of Pocket Maximum. Prescription Drugs that are not on the Formulary, but are approved by Anthem as exceptions will accumulate towards the In Network Out of Pocket Maximum.

In Network Out of Pocket Maximums

Your In Network Out of Pocket Maximum is determined by the number of Members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the In Network Individual Out of Pocket Maximum applies. If more than one (1) person is enrolled in this Plan, then both the In Network Individual Out of Pocket Maximum and the In Network Family Out of Pocket Maximum apply.

- **In Network Individual Out of Pocket Maximum for one (1) Member**
  - Once the total allowable charges applying to the In Network Individual Out of Pocket Maximum have been met, Anthem will provide 100% of the Maximum Allowed Amount for the In Network Covered Services for the remainder of that Benefit Period.
- **In Network Family Out of Pocket Maximum for two (2) or more Members**
  - Once the total allowable charges applying to the In Network Individual Out of Pocket Maximum have been met for one (1) Member, Anthem will provide benefits at 100% of the Maximum Allowed Amount for In Network Covered Services for the remainder of that Benefit Period for that Member. The Member's In Network Individual Out of Pocket Maximum will contribute towards the In Network Family Out of Pocket Maximum.
  - All other family Members will be subject to the remainder of the In Network Family Out of Pocket Maximum until the In Network Family Out of Pocket Maximum is satisfied. All Cost Shares paid for Covered Services by each additional individual Member in a family during a Benefit Period will contribute to the remainder of the In Network Family Out of Pocket Maximum. Once the total allowable charges applying to the In Network Family Out of Pocket Maximum have been met, Anthem will provide benefits at 100% of the Maximum Allowed Amount for In Network Covered Services for the remainder of that Benefit Period.

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

Out of Network Out of Pocket Maximums

Your Out of Network Out of Pocket Maximum is determined by the number of Members enrolled in this Plan. If only one (1) person is enrolled in this Plan, then only the Out of Network Individual Out of Pocket Maximum applies. If more than one (1) person is enrolled in this Plan, then both the Out of Network Individual Out of Pocket Maximum and the Out of Network Family Out of Pocket Maximum apply.

- **Out of Network Individual Out of Pocket Maximum for one (1) Member**
  - Once the total allowable charges applying to the Out of Network Individual Out of Pocket Maximum have been met, Anthem will provide 100% of the Maximum Allowed Amount for the Out of Network Covered Services for the remainder of that Benefit Period.
- **Out of Network Family Out of Pocket Maximum for two (2) or more Members**
  - Once the total allowable charges applying to the Out of Network Individual Out of Pocket Maximum have been met for one (1) Member, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Out of Network Covered Services for the remainder of that Benefit Period for that Member. The Member's Out of Network Individual Out of Pocket Maximum will contribute towards the Out of Network Family Out of Pocket Maximum.
  - All other family Members will be subject to the remainder of the Out of Network Family Out of Pocket Maximum until the Out of Network Family Out of Pocket Maximum is satisfied. All Cost Shares paid for Covered Services by each additional individual Member in a family during a Benefit Period will contribute to the remainder of the Out of Network Family Out of Pocket Maximum. Once the total allowable charges applying to the Out of Network Family Out of Pocket Maximum have been met, Anthem will provide benefits at 100% of the Maximum Allowed Amount for Out of Network Covered Services for the remainder of that Benefit Period.

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

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

Claims and Payments

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

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

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

GETTING APPROVAL FOR BENEFITS

Your Plan includes the Prior Authorization processes of Precertification and Predetermination. The Plan also performs Post Service Clinical Claims Review. These processes help Your Plan decide when services should be covered. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered.

When setting or place of service is part of the review, services that can be safely given to You in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization

Network Providers must obtain Precertification in order for You to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and Pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if You have not first tried other Medically Necessary and more cost-effective treatments.

If You have any questions about the information in this part, You may call customer service at **1-855-383-7247**.

Types of Prior Authorization Requests

- **Precertification** – A required review of a service, treatment of admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For labor/childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check Your Agreement to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Agreement or is Experimental / Investigative as that term is defined in this Agreement.

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

Services for which Precertification is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

- All inpatient Facility admissions (except for Emergency admissions and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time);
- Mental Health and Substance Abuse services:
  - Inpatient Facility admissions for Mental Health and Substance Abuse services, including detoxification and rehabilitation (except for Emergency admissions)
  - Residential treatment (including detoxification and rehabilitation)
  - Partial Hospitalization
  - Intensive outpatient programs
  - Transcranial Magnetic Stimulation (TMS)
  - Behavioral health treatment for Pervasive Developmental Disorder or autism;
- Skilled Nursing Facility stays;
- Bariatric surgery and organ and tissue transplants Center of Medical Excellence (CME) procedures (see Center of Medical Excellence (CME) requirements under WHAT IS COVERED – MEDICAL);
- All Infusion Therapy (in any setting) inclusive of Specialty Drugs and related services (for each course of Therapy) in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or Your home or other residential setting;
- Home Care Services;
- Hospice Care;
- Surgical procedures, wherever performed;
- The following diagnostic procedures and tests, including advanced imaging procedures, wherever performed:
  - Computerized Tomography (CT)
  - Computerized Tomography Angiography (CTA)

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology (NC)
- Positron Emission Tomography (PET)
- PET and PET/CT Fusion
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Echocardiogram
- Magnetoencephalography(MEG)
- Sleep study
- Anesthesia for gastrointestinal endoscopic procedures
- Capsule endoscopy-gastrointestinal track
- Manipulation of spine under anesthesia;

- The following reconstructive services:
  - Facial dermabrasion
  - Rosacea treatment
  - Scar revision
  - Tattooing;
- Genetic testing for cancer susceptibility;
- The following prosthesis and assistive devices:
  - Custom prosthesis
  - Cochlear implant
  - Speech generating devices
  - External ambulatory insulin delivery system
  - Functional neuromuscular stimulator
  - Automatic external defibrillator
  - High frequency chest wall oscillation system vest
  - Intrapulmonary percussive ventilation system
  - Neuromuscular stimulator, electronic shock unit
  - External mobile cardiovascular telemetry with electrocardiographic recording
  - Standing Frame system

- Sleep equipment and supplies
- Wheelchairs and Accessories;

- Ambulance in a non-Emergency.

For a list of current procedures requiring Precertification, please call customer service at **1-855-383-7247**.

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

Who is responsible for Precertification	
Services given by an In Network Provider	**Services given by a BlueCard or Out of Network Provider**
Provider	• Member must get Precertification • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part • For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time

We will use our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventive care clinical coverage guidelines to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by us, notwithstanding that it might otherwise be found to Investigational as that term is defined in the Plan otherwise. Your Agreement takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which we based our determination. To ask for this information, call the Precertification phone number on the back of Your identification card.

GETTING APPROVAL FOR BENEFITS

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost-effective, value-based and/or quality services.

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

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

You may determine whether a Provider is participating in certain programs by checking Your on-line Provider directory, on-line pre-certification list or contacting customer service at **1-855-383-7247**.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Physician with knowledge of Your medical condition, could without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** – A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** – A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also Retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, we will follow State laws. If You live in and/or get services in a state other than the State where Your Agreement was issued other State-specific requirements may apply. You may call customer service at **1-855-383-7247** for more details.

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

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

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

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

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

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a covered benefit under Your Plan;
- The service cannot be subject to an Exclusion under Your Plan; and
- You must not have exceeded any applicable limits under Your Plan.

Health Plan Individual Case Management

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

Our Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan case management staff. These Case Management programs are separate from any Covered Services You are receiving.

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

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

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Agreement. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem Blue Cross. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify You or Your representative in writing.

WHAT IS COVERED – MEDICAL

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

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

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

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

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

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

You must satisfy the medical Deductible before we will make payment for services You receive, except for certain services as stated in SUMMARY OF BENEFITS. Additionally, the medical Deductible is explained under YOUR PAYMENT RESPONSIBILITY.

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

Eligibility for coverage cannot be based on health status-related factors: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor determined appropriate by the United States Secretary of Health and Human Services. This Agreement does not discriminate against an individual based on any of the following factors: age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Acupuncture

Please see "Therapy Services" later in this part.

Allergy Services

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

Ambulance Services (Air, Ground and Water)

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

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

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and/or injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. This includes ground, fixed wing, rotary wing or water transportation. Ambulance Services do not include transportation by car, taxi, bus,

gurney van, wheelchair van and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Provider.

- For ground ambulance, You are taken:
  - From Your home, scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital; or
  - Between a Hospital and a Skilled Nursing Facility (ground transportation) or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when we require You to move from an Out of Network Hospital to an In Network Hospital
  - Between a Hospital and an approved Facility.

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

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility. If requested through a **911** call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if You are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by us prior to the benefits being paid.

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

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

IN AN EMERGENCY: OUT OF NETWORK PROVIDERS MAY BILL YOU FOR ANY CHARGES THAT EXCEED THE REASONABLE AND CUSTOMARY VALUE.

IN A NON EMERGENCY: OUT OF NETWORK PROVIDERS MAY BILL YOU FOR ANY CHARGES THAT EXCEED THE MAXIMUM ALLOWED AMOUNT.

Ground Ambulance

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

Air and Water Ambulance

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

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate Facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of Facilities may include, but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate Facilities.

Fixed and Rotary Wing Air Ambulance

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

Autism

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

Bariatric Surgery

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

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

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

Benefits for Covered Services and supplies provided for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism are subject to the same cost-sharing provisions as other medical services or Prescription Drugs covered by this Agreement, except as specifically stated in this section. These benefits are subject to all other terms, conditions, limitations and exclusions, including WHAT IS COVERED – MEDICAL. Services may be provided in a Provider's office, in the Member's home or school or in a Facility, such as the inpatient or outpatient department of a Hospital. See the section "Mental Health and Substance Abuse (Chemical Dependency) Services" below for more detail.

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

For purposes of this section **Behavioral Health Treatment** means professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

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

ii. Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.

iii. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism.

iv. Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate.

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

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

For purposes of this section **Intensive Behavioral Intervention** means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning and across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

For purposes of this section **Pervasive Developmental Disorder** or **Autism** is used as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

For purposes of this section **Qualified Autism Service Provider** is either of the following:

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

For purposes of this section **Qualified Autism Service Professional** is a Provider who meets all of the following requirements:

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

For purposes of this section **Qualified Autism Service Paraprofessional** is an unlicensed and uncertified individual who meets all of the following requirements:

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

Conditions of Services

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

Cardiac Rehabilitation Therapy

Please see “Therapy Services” later in this part.

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

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

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

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

Note: An In Network Provider is not necessarily a CME Facility. Information on CME Facilities can be obtained by calling **1-855-383-7247**.

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

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

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

- Transportation for the Member to and from the CME up to $130 per trip for a maximum of three (3) trips (one (1) pre-surgical visit, the initial surgery and one (1) follow-up visit).
- Transportation for one (1) companion to and from the CME up to $130 per trip for a maximum of two (2) trips (the initial surgery and one (1) follow-up visit).

- Hotel accommodations for the Member and one (1) 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 (1) room, double occupancy.
- Hotel accommodations for one (1) companion not to exceed $100 per day for the duration of the Member's initial surgery stay, up to four (4) days. Limited to one (1) room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to four (4) days per trip. Meals, tobacco, alcohol and Drug expenses are excluded from coverage.

Customer service will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service toll free at **1-855-383-7247**. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

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

Coverage will not be denied, if otherwise available under this Agreement for the costs of transplantation services based upon HIV status.

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

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

- the recipient or
- the donor

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

Transplant Travel Expense. Certain travel expenses incurred by the Member, up to a maximum $10,000 Anthem payment per transplant will be covered for the recipient or donor in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME qualified to provide services, provided the expenses are Authorized by us in advance. All travel expenses are limited up to the maximum set forth in Internal Revenue Code at the time services are rendered and must be approved by Anthem in advance. Travel expenses include the following for the recipient (and one (1) companion) or the donor:

- Ground transportation to and from the CME when the designated CME is seventy-five (75) miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is three-hundred (300) miles or more from the recipient's or donor's place of residence.
- Lodging, limited to one (1) room, double occupancy.
- Meals, tobacco, alcohol, Drug expenses and other non-food items are excluded.

Note: When the Member recipient is under eighteen (18) years of age, this benefit will apply to the recipient and two (2) companions or caregivers.

When You request reimbursement of covered travel expenses, You must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call customer service at **1-855-383-7247** for further information and/or to obtain the travel reimbursement form.

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

Unrelated Donor Searches

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

Each Year thousands of people's lives are saved by organ transplants. The success rate of transplants is rising, but more donations are needed. This is a unique opportunity to give the gift of life. Anyone who is eighteen (18) years of

age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. Today, it is possible to transplant about twenty-five (25) different organs and tissues. Your decision to become a donor could someday save or prolong the life of someone You know, even a close friend or family member. If You decide to become a donor, talk it over with Your family. Let Your Physician know Your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with Your driver's license or identification card.

Chemotherapy

Please see "Therapy Services" later in this part.

Child Dental Services

Please see "Dental Services – Child" later in this part.

Child Vision Services

Please see "Vision Services – Child" later in this part.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

a. The National Institutes of Health.

b. The Centers for Disease Control and Prevention.

c. The Agency for Health Care Research and Quality.

d. The Centers for Medicare & Medicaid Services.

e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below:

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

2. Studies or investigations done as part of an Investigational new Drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for Drug trials which are exempt from the Investigational new Drug application.

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

Routine patient care costs include items, services and Drugs provided to You in connection with an approved Clinical Trial and that would otherwise be covered by this Agreement.

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

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

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

Dental Services

Preparing the Mouth for Medical Treatments

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

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

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

Treatment of Accidental Injury

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

Benefits are available for the services of a Physician treating an Accidental Injury to Your natural teeth when You receive treatment within one (1) Year following the injury or within one (1) Year following Your Effective Date, whichever is later. Treatment excludes orthodontia.

Dental Anesthesia

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

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

Medically Necessary dental or orthodontic services are covered if they are integral to Reconstructive Surgery for cleft palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Important: If You decide to receive Dental Services that are not covered under this Agreement, an In Network Provider who is a dentist may charge You his or her usual and customary rate for those services. Prior to providing You with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes

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each anticipated service to be provided and the estimated cost of each service. If You would like more information about the Dental Services that are covered under this Agreement, please call customer service at **1-855-383-7247**.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for You and Your dentist. It gives You and the dentist an idea of what Your out of pocket costs will be. This allows You and Your dentist to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodonic, oral surgery or orthodontic care.

The pretreatment estimate is recommended, but not required for You to get benefits for Covered Services.

A pretreatment estimate does not Authorize treatment or determine its Medical Necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on Your current eligibility and the Agreement benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to us at the time of the completed dental care service(s). Sending in other claims or changes to Your eligibility or to the Agreement may affect our final payment.

You can ask Your dentist to send in a pretreatment estimate for You, or You can send it to us Yourself. Please include the procedure codes for the services to be performed (Your dentist can give these to You). Pretreatment estimate requests can be sent to Anthem Blue Cross. If You have questions on where to send the estimate, call us at the number on the back of Your ID card.

Dental Services – Child

For Members until the last day of the month in which they turn nineteen (19) years of age.

The dental benefits described in this section only apply to Members until the last day of the month in which they turn nineteen (19) years of age. See “Dental – Child Dental Services” in the SUMMARY OF BENEFITS for additional information.

This Agreement covers the dental services below for Members to the end of the month in which they turn age nineteen (19) when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for Your dental condition, the Plan will cover the least expensive treatment.

Your Dental Benefits

Anthem does not determine whether the dental services (except orthodontic services) listed in the following sections are Medically Necessary to treat Your specific condition or restore Your dentition.

When orthodontic care is covered by this Agreement, claims will be reviewed to determine if it was Medically Necessary orthodontic care. See "Orthodontic Care" below for more information.

Your dentist may recommend or prescribe dental care services that are not covered, are cosmetic in nature, or exceed the benefit maximums of this Agreement; however, there may be other dental services available that are covered. These other services are called optional treatments. If an allowance for an optional treatment is available, You may apply this allowance to the dental service recommended by Your dentist. You will have to pay for any costs that exceed the allowance, in addition to any Deductible, Copayments or Coinsurance You may have.

The decision as to what dental care treatment is best for You is solely between You and Your dentist.

Diagnostic and Preventive Services

- **Oral evaluations** – Any type of evaluation (check-up or exam) is covered up to two (2) times per Benefit Period.
- **Consultations** – This benefit includes Specialist consultations.
- **Radiographs (x-rays)**
    - **Bitewings** – Those that are made during periodic exams are covered up to one (1) series (four (4) films) in any six (6) month period Isolated bitewing or periapical films are covered on an emergency basis.
    - **Full mouth** – Those that are made during periodic exams are covered up to one (1) in any twenty-four (24) month period.
    - **Panoramic** – Covered once in any twenty-four (24) month period.
- **Dental cleaning (prophylaxis)** – Covered up to two (2) times per Benefit Period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.
- **Fluoride treatment** - Topical application of fluoride or fluoride varnish.
- **Dental sealant treatments** – Covered for first and second permanent molars only.
- **Space maintainers** (including acrylic and fixed band type)
- **Preventive dental education and oral hygiene instruction**

Basic Restorative Services

- **Emergency treatment** – Emergency (palliative) treatment for the temporary relief of pain or infection.
- **Restorations (fillings)** – Restorations are limited by the following conditions:

- If the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries (decay), any other restoration, such as a crown, is considered an optional treatment.
- Composite resin or acrylic restorations on posterior (back) teeth is considered optional treatment.
- Only micro filled resin restorations that are non-cosmetic are covered.
- Replacement of a restoration is covered only if it is defective, as shown by conditions as recurrent decay or fracture.

- **Pins and pin build-up** – Covered when given with a restoration treatment or service.
- **Sedative base and sedative fillings**
- **Basic tooth extractions**

Endodontic Services

- **Direct pulp capping**
- **Therapeutic pulpotomy**
- **Apexification filling with calcium hydroxide**
- **Root amputation**
- **Root canal therapy** – Retreatment of previous root canal and culture canal are subject to the following conditions:
  - Retreatment of root canals is covered only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
  - Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- **Apicoectomy**
- **Vitality tests**

Periodontal Services

- **Emergency treatment** – This includes treatment for periodontal abscess and acute periodontitis.
- **Periodontal scaling, root planing and subgingival curettage** – Covered up to five (5) quadrant treatments in any twelve (12) month period.
- **Gingivectomy**
- **Osseous or muco-gingival surgery**
- **Adjunctive General Services** – Covered for the following**:**
  - Local anesthetics.
  - Oral sedatives and nitrous oxide when dispensed at a dental office by a provider acting within the scope of

their licensure.

Oral Surgery Services

- **Oral Surgery Services** - These services include post-operative care such as examinations, suture removal and treatment of complications.
- **Surgical extractions** - Removal of impacted teeth is covered only when evidence of pathology exists.
- **Alveolectomies**
- **Biopsy of oral tissues**
- **Excision of cysts and neoplasms**
- **Frenectomy**
- **Incision and drainage of abscesses**
- **Root recovery (separate procedure)**
- **Treatment of palatal torus and mandibular torus**
- **Adjunctive General Services** - Intravenous conscious sedation, IV sedation, and general anesthesia – Covered only when given in conjunction with complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.

Major Restorative Services – Benefits include the following:

- **Crowns** – including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are covered as followed:
  - Replacement of each unit is limited to once in a thirty-six (36) month period, except when crown is no longer functional.
  - Only acrylic crowns and stainless steel crowns are covered for children through age eleven (11). If other types of crowns are chosen for children through age eleven (11), it will be considered an optional treatment
  - Crowns are covered only if there is not enough retentive quality left in the tooth to hold a filling.
  - Veneers posterior to the second bicuspid are considered and optional treatment. We will pay up to the allowance for a cast full crown.
- **Recementation of crowns, inlays, and onlays**
- **Cast post and core, including cast retention under crowns**
- **Crown repair**

Prosthodontic Services – Benefits include the following:

- **Fixed bridges** – Bridges made of cast, porcelain baked with metal, or plastic processed to gold are covered as follows:
  - Members who are age sixteen (16) and older are covered. Fixed bridges for Members under age sixteen (16) are considered optional treatment and will be covered up to the allowance for a space maintainer.
  - A fixed bridge is covered when it is necessary to replace a missing permanent anterior (front) tooth.
  - Fixed bridges are covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an optional treatment.
  - Fixed bridges used to replace missing posterior teeth are considered optional treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic.
  - Fixed bridges are considered optional treatment when provided in connection with a partial denture on the same arch.
  - Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair.

Note: We will cover up to five (5) units of crown or bridgework per arch. Upon the sixth (6^{th}) unit, the treatment is considered full mouth reconstruction and is an optional treatment.

- **Recementation of bridges**
- **Repair or replacement of abutments or pontics**
- **Dentures** – Including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers. Dentures are covered as follows:
  - Replacement for partial dentures is not covered within thirty-six (36) months of initial placement unless:
  - It is necessary due to natural tooth loss where the addition or replacement of the existing partial is not possible; or
  - The denture is unsatisfactory and cannot be made satisfactory.
  - Coverage for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen, and is not necessary to satisfactorily restore an arch, the patient is responsible for all additional charges.
  - A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Any other treatments for these cases are considered optional treatments.
  - Full upper and/or lower dentures are not to be replaced within any thirty-six (36) month period unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
  - Coverage for complete dentures will be limited to the benefit for a standard procedure. If a more personalized or specialized treatment is chosen, the patient will be responsible for all additional charges.

- **Chairside or laboratory relines or rebases** – Covered once per arch in any twelve (12) month period.
- **Denture repairs and adjustments**
- **Tissue conditioning** – Covered twice per denture.
- **Denture duplication**
- **Stayplates** – Covered only when used as anterior space maintainers for children.

Orthodontic Services

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. To be considered Medically Necessary orthodontic care, the service must be pre-Authorized by us. Anthem will Authorize the service if it is necessary to restore the form and function of the oral cavity, such as through a result of injury or dysfunction resulting from congenital deformities. Medically Necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered Medically Necessary orthodontic care, at least one of the following must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or Your orthodontist should send Your treatment plan to us to find out if it will be covered under this Agreement.

Benefits may include the following:

- **Limited Treatment** – Treatments which are not full treatment cases and are usually done for minor tooth movement.
- **Interceptive Treatment** – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- **Comprehensive (complete) Treatment** – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- **Removable Appliance Therapy** – An appliance that is removable and not cemented or bonded to the teeth.
- **Fixed Appliance Therapy** – A component that is cemented or bonded to the teeth.
- **Other Complex Surgical Procedures** – Surgical exposure of impacted or unerupted tooth for orthodontic

reasons; or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before You were covered by this Agreement will be covered on a pro-rated basis.

Benefits do not include:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Agreement in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made:

1. when treatment begins (appliances are installed), and
2. at six (6) month intervals thereafter, until treatment is completed or this Agreement's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to You and Your orthodontist indicating the estimated Maximum Allowed Amount, including any amount You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified Your Agreement's benefits and Your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to You and Your orthodontist. This again serves as the claim form to be sent in six (6) months after the appliances are placed.

Please submit appeals regarding Your dental coverage to the following address:

Anthem Blue Cross

P.O. Box 1122

Minneapolis, MN 55440-1122

Diabetes Equipment, Education and Supplies

Certain prosthesis and assistive devices require Precertification (see GETTING APPROVAL FOR BENEFITS for details).

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Copayments, as any other medical condition. Benefits will be provided for:

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

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

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

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

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

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

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

Diagnostic

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

Diagnostic Services

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

- **Diagnostic Laboratory and Pathology Services**
- **Diagnostic Imaging Services and Electronic Diagnostic Tests**
  - X-rays / regular imaging services
  - Ultrasound
  - Electrocardiograms (EKG)
  - Electroencephalography (EEG)
  - Echocardiograms
  - Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
  - Tests ordered before a surgery or admission.
- **Advanced Imaging Services**

  Benefits are also available for advanced imaging services, which include but are not limited to:
  - Computed Tomography (CT) scan
  - Computed Tomography Angiography (CTA) scan
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Magnetic Resonance Spectroscopy (MRS)
  - Nuclear Cardiology (NC)
  - Positron Emission Tomography (PET) scans
  - PET/CT Fusion scans
  - Quantitative Computed Tomography (QCT) Bone Densitometry
  - Diagnostic CT Colonography

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

Dialysis

Please see "Therapy Services" later in this part.

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

Certain prosthesis and assistive devices require Precertification (see GETTING APPROVAL FOR BENEFITS for details).

Covered Services are subject to change. For a list of current Covered Services, please call customer services at **1-855-383-7247**.

Durable Medical Equipment and Medical Devices

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

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

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

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

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

- Standard curved handle or quad cane and replacement supplies,
- Standard or forearm crutches and replacement supplies,
- Dry pressure pad for a mattress,
- IV pole,
- Enteral pump and supplies,
- Bone stimulator,
- Cervical traction (over door) equipment,
- Phototherapy blankets for treatment of jaundice in Newborns,
- Non-segmental home model pneumatic compressor for the lower extremities.

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

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

Prosthetics and Devices

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

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

- Artificial limbs and accessories.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- Breast prosthesis (whether internal or external) after a Medically Necessary mastectomy, as required by the Women's Health and Cancer Rights Act. Custom-made prostheses when Medically Necessary and up to three

(3) brassieres required to hold a prosthesis every twelve (12) months and adhesive skin support attachment for use with external breast prosthesis.

- Compression burn garments and lymphedema wraps and garments.
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect.
- Colostomy supplies.
- Restoration prosthesis (composite facial prosthesis).
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy.
- Cochlear implants.

Medical and Surgical Supplies

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

Blood and Blood Products

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

Ostomy and Urological Supplies

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

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles – bedside and leg

- Dressing Supplies
- Irrigation Supplies
- Lubricants
- Miscellaneous Supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices.
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof.

Diabetic Equipment and Supplies

Diabetic equipment and supplies for the treatment of diabetes are covered. Please see "Diabetes Equipment, Education and Supplies" above.

Asthma Treatment Equipment and Supplies

Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Emergency Care

Medically Necessary services will be covered whether You get care from an In Network or Out of Network Provider. For information on Your Cost Shares for Emergency Services, please see the SUMMARY OF BENEFITS, the section "Inter-Plan Arrangements" in HOW YOUR COVERAGE WORKS and the "Ambulance Services" section above.

Emergency Services

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

Emergency (Emergency Medical Condition)

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

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

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

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

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

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

Emergency Care

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

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

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

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

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

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

Family Planning Services

Covered Services include:

- Family planning counseling and education You are eligible for counseling as related to contraception and follow-up services related to the Drugs, devices, products and procedures including but not limited to managing side effects and counseling as to continued adherence and device insertion and removal (see "Preventive Care" later in this part).
- Over the counter FDA approved contraceptive methods as prescribed by a health care Provider (see "Preventive Care" later in this part).
- Women's contraceptives and sterilization procedures (see "Preventive Care" later in this part).
- Abortions.

Habilitation Services

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

Health Education

Health education counseling, programs and material to help You take an active role in protecting and improving Your health, including programs for tobacco cessation, chronic conditions (such as diabetes and asthma) and stress management. At Anthem Blue Cross we believe it is important for You to have control of Your health care and have access to health programs to help You establish or maintain good health habits.

Hearing Services

Covered Services include:

- Routine hearing screenings (see "Preventive Care" later in this part).
- Hearing exams to determine the need for hearing correction (see "Preventive Care" later in this part).
- Services related to the ear or hearing, such as outpatient care to treat an ear infection and outpatient Prescription Drugs, supplies and supplements (see "Office Visits" later in this part and WHAT IS COVERED – PRESCRIPTION DRUGS).
- Cochlear implants (see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this part).

Home Care Services

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

Benefits are available for Covered Services performed by a Home Health Care Agency or other professional Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Physician and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff. Covered Services include but are not limited to:

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

Limitations:

- Out of Network Providers are limited to one-hundred (100) visits per Benefit Period

- Limited to up to two (2) hours per visit for visits by a nurse, medical social worker or physical, occupational, or speech therapist and up to four (4) hours per visit for visits by a home health aide.
- Up to three (3) visits per day.
- The ordering Physician must be treating the illness or injury necessitating the Home Health Care and renew the order for these services once every thirty (30) days.
- Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.
- We will not cover personal comfort items.
- These limitations and Home Health Care benefits (as described in this section) do not include Behavioral Health Treatment for Pervasive Developmental Disorder or Autism (see "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" above).

Hospice Care

Precertification is required for Hospice Care (see GETTING APPROVAL FOR BENEFITS for details).

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

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

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

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

Limitations:

The following services, supplies or care are not covered:

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

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

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

Infusion Therapy

Please see “Therapy Services” later in this part.

Inpatient Facility Services

Precertification is required for all inpatient Facility admissions. Precertification is not required for Emergency and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer. For Emergency admissions, You, Your authorized representative or Physician must tell us within forty-eight

(48) hours of the admission or as soon as possible within a reasonable period of time (see GETTING APPROVAL FOR BENEFITS for details).

Inpatient Facility Services or "Hospital" includes an acute psychiatric Facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide twenty-four (24) hour acute inpatient care. For the purpose of this Plan, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute twenty-four (24) hour Facility as defined in California Health and Safety code 1250.2. Also see the definition of "Residential Treatment Center."

Inpatient Facility Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two (2) or more beds.
- A private room. The most Anthem will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation Facilities are available.
- A room in a Special Care Unit approved by us. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Physicians.

- A personal bedside exam by another Physician when asked for by Your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity Care

Maternity Services

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

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

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or Newborn to less than forty-eight (48) hours after vaginal birth, or less than ninety-six (96) hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get Precertification from us before prescribing a length of stay which is not more than forty-eight (48) hours for a vaginal birth or ninety-six (96) hours after a C-section. If the inpatient care is for a time less than forty-eight (48) or ninety-six (96) hours, as applicable, a post-discharge follow-up visit for the mother and Newborn within forty-eight (48) hours of discharges is covered when prescribed by the treating Physician. This visit shall include, at a minimum, parent education, assistance and training in breast or bottle-feeding and the

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performance of any necessary maternal or neonatal physical assessments.

Mental Health and Substance Abuse (Chemical Dependency) Services

Precertification is required for certain Mental Health and Substance Abuse services except in an Emergency (for a list of services that require Precertification, see GETTING APPROVAL FOR BENEFITS).

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

Coverage is provided for Severe Mental Illness for a person of any age and Serious Emotional Disturbances of a Child, as defined by the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM), and any Mental Health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM IV). Coverage is also provided for Substance Abuse treatment.

Covered Services include the following:

- **Outpatient Office Visits**, which include:
  - Individual and group Mental Health evaluation and treatment
  - Outpatient services to monitor Drug therapy
  - Methadone maintenance treatment
  - Individual and group chemical dependency counseling
  - Medical treatment for withdrawal symptoms
  - Behavioral Health Treatment for Pervasive Developmental Disorders or Autism delivered in an office setting
- **Other Outpatient Items and Services**, including:
  - Partial Hospitalization programs and intensive outpatient programs
  - Behavioral Health Treatment for Pervasive Developmental Disorder or Autism delivered outside an office setting, such as in the home or a school setting
  - Outpatient psychological testing
  - Day treatment programs for Substance Abuse
  - Intensive outpatient programs for Substance Abuse
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program for Mental Health
  - Electroconvulsive therapy
- **Inpatient Services** in a Hospital or any Facility that we must cover per State law. Inpatient benefits include the following:

- Inpatient psychiatric Hospitalization, including room and board, Drugs, and services of Physicians and other Providers who are licensed health care professionals acting within the scope of their license
- Psychiatric observation for an acute psychiatric crisis
- Detoxification - medical management of withdrawal symptoms, including room and board, Physician services, Drugs, dependency recovery services, education and counseling
- Residential treatment which is specialized twenty-four (24) hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
  - Treatment in a crisis residential program:
    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.
- Transitional residential recovery services for substance abuse (chemical dependency)
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism delivered in an inpatient Facility

- **Inpatient Physician/Surgeon fee** when billed separately from the inpatient services

Providers who can provide Covered Services include:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Qualified Autism Service Providers, Qualified Autism Service Professionals and Qualified Autism Service Paraprofessionals. See the definitions of these in the section “Behavioral Health for Pervasive Developmental Disorder or Autism” above.

Occupational Therapy

Please see “Therapy Services” later in this part.

Office Visits

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

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

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

Covered Services include:

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

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

- **Retail Health Clinic Visit** for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children
- **Walk-In Physician's Office** for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Physician's office
- **Urgent Care** as described in "Urgent Care" later in this part
- **Online Care Visits** when available in Your area. Covered Services include a medical visit with the Physician using the internet by a webcam, chat or voice. Online care visits do not include reporting normal lab or other test results, requesting Office Visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to Physicians outside the online care panel, benefit Precertification, or Physician to Physician discussions
- **Telehealth** as described in "Telehealth" later in this part.
- **After Hours Care.** If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call **911** or go to the

nearest Emergency room (see WHAT IS NOT COVERED (Exclusions) – MEDICAL). This exclusion does not apply to Emergency Services.

- **Second Opinions.** If You have a question about Your condition or about a plan of treatment, which Your Physician has recommended, You may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the benefits, limitations and exclusions of this Agreement. If You wish to receive a second medical opinion, remember that greater benefits are provided when You choose an In Network Provider. You may also ask Your Physician to refer You to an In Network Provider to receive a second opinion.

Office Visits – Additional Services in an Office Setting

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

Certain Reconstructive services, wherever performed, require Precertification (see GETTING APPROVAL FOR BENEFITS for details).

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

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

Orthotics

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

Osteoporosis

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

Outpatient Facility Services

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

Certain Reconstructive services, wherever performed, require Precertification (see GETTING APPROVAL FOR BENEFITS for details).

Your Agreement includes Covered Services in an:

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

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

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs dispensed through the Facility (includes infusion therapy),
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services include Physical, Speech and Occupational Therapy,
- Chemotherapy,
- Radiation,
- Dialysis.

Phenylketonuria (PKU)

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

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. “Formula” means an enteral product or products for use at home. The formula must be prescribed by a Physician or

nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under Your Agreement's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

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

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

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

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Physical Therapy

Please see "Therapy Services" later in this part.

Preventive Care

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

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

Preventive care services will meet requirements of federal and State law. Preventive care services stated below are covered by this Agreement with no Deductible, Copayments or Coinsurance when You use an In Network Provider. That means Anthem pays 100% of the Maximum Allowed Amount. If obtained from an Out of Network Provider, the Member will pay 60% Coinsurance plus all charges in excess of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force. Examples include screenings for:
    a. Breast cancer,
    b. Cervical cancer,

c. Colorectal cancer,
d. High blood pressure,
e. Type 2 Diabetes Mellitus,
f. Cholesterol and
g. Child and adult obesity;

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
   a. The American Academy of Pediatrics Bright Futures Recommendations for pediatric preventive health care and
   b. The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children;
4. Additional preventive care and screening for women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including:
   a. Women's contraceptives, sterilization procedures and counseling. This includes the eighteen (18) FDA-approved contraceptive methods:
      i. Generic contraceptive Drugs unless there is no Generic equivalent, the Generic Drug is unavailable or the Generic Drug would be medically inappropriate as determined by Your Physician at which time the Brand Name Drug would be covered with no Deductible, Copayment or Coinsurance when obtained from an In Network Pharmacy. Brand Name Drugs (with a Generic equivalent) will be covered as Preventive Care benefits when Medically Necessary, otherwise they will be covered under the Prescription Drug Benefit subject to the applicable Prescription Drug Deductible, Copayment and/or Coinsurance amounts as described in the SUMMARY OF BENEFITS. Also see WHAT IS COVERED – PRESCRIPTION DRUGS. If there is one or more therapeutic equivalent of a contraceptive Drug, device or product, Anthem will cover at least one, if available at a $0 cost sharing.
      ii. Injectable contraceptives and patches,
      iii. Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants,
      iv. Over-the-counter FDA-approved contraceptives for women as prescribed,
      v. Family planning counseling and education,
      vi. Voluntary sterilization procedures,

vii. Education and counseling as to contraception and follow-up services related to the Drugs, devices, products and procedures including but not limited to managing side effects and counseling for continued adherence and device insertion and removal,

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) per calendar year or as required by law. Breast pumps are covered under Your Agreement's medical benefits,
c. Gestational diabetes screening,
d. Well woman visits that are age and developmentally appropriate, including preconception and prenatal care,
e. Screening and counseling for sexually transmitted infections,
f. Screening and counseling for Human Immunodeficiency Virus (HIV),
g. Screening and counseling for interpersonal and domestic violence and
h. Testing for Human Papillomavirus (HPV).

Examples of preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the Office Visit associated with administering the injectable vaccination when ordered by Your Physician.
- Human papillomavirus (HPV) test for cervical cancer.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate laboratory tests and procedures and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), vision (such as hypertension, diabetes, glaucoma or macular degeneration), and hearing screenings in connection with the routine physical exam.

- Immunizations including those recommended by the Advisory Committee on Immunization Practices for Members age nineteen (19) and above.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases and smoking cessation programs.
- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; and the Office Visit related to these services.

You may call customer service at **1-855-383-7247** for more details about these services or view the federal government's websites:

- **https://www.healthcare.gov/what-are-my-preventive-care-benefits**;
- **http://www.ahrq.gov**; or
- **http://www.cdc.gov/vaccines/acip/index.html**.

Prosthetics

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

Pulmonary Rehabilitation

Please see "Therapy Services" later in this part.

Radiation Therapy

Please see "Therapy Services" later in this part.

Rehabilitation and Habilitation Services

Precertification is required for a Skilled Nursing Facility and certain Mental Health and Substance Abuse services (see GETTING APPROVAL FOR BENEFITS for details).

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

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

Habilitation services are health care services that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see "Therapy Services" later in this part.

Residential Treatment Center

Please see "Inpatient Facility" in this part.

Skilled Nursing Facility

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

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

We cover the following services:

- Physician and nursing services,
- Room and board,
- Drugs prescribed by a Physician as part of Your plan of care in the Skilled Nursing Facility,
- Durable Medical Equipment if Skilled Nursing Facilities ordinarily furnish the equipment,
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide,
- Medical Social Services,

- Blood, blood products and their administration,
- Medical Supplies,
- Physical, Occupational and speech therapy, and
- Respiratory therapy.

Limitations:

- Out of Network Providers are limited to one-hundred (100) days per Skilled Nursing Day Allowance. A Skilled Nursing Day Allowance begins on the date the enrollee is admitted to a hospital or skilled nursing facility at a skilled level of care. A Skilled Nursing Day Allowance ends on the date the enrollee has not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for sixty (60) consecutive days. A new Skilled Nursing Day Allowance can begin only after any existing Skilled Nursing Day Allowance ends. This limit does not apply to Mental Health and Substance Abuse Services or Behavioral Health Treatment.
- You must be under active supervision of a Physician treating Your illness or injury.

Speech Therapy

Please see "Therapy Services" later in this part.

Surgery

Surgical procedures, wherever performed, require Precertification (see GETTING APPROVAL FOR BENEFITS for details).

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

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

Bariatric Surgery

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

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate;
- Orthognathic (jawbone) surgery for a medical condition or injury which prevents normal function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone;
- Oral / surgical correction of Accidental Injuries;
- Treatment of lesions, removal of tumors and biopsies;
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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

Reconstructive Surgery

Benefits include Medically Necessary Reconstructive Surgery to correct or repair abnormal structures of the body caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Mastectomy and Lymph Node Dissections

A Member who is getting benefits for a mastectomy or for Follow-up Care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

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

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

Telehealth

Benefits are provided for Covered Services that are appropriately provided through Telehealth, subject to the terms and conditions of this Agreement. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include consultations between the patient and the health care Provider, or between health care Providers, by telephone, facsimile machine or electronic mail.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Precertification is required for certain diagnostic procedures and tests (see GETTING APPROVAL FOR BENEFITS for details).

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

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

Therapy Services

Precertification is required for Infusion Therapy (in all settings) (see GETTING APPROVAL FOR BENEFITS for details).

Physical Medicine Therapy Services

Your Plan includes coverage for therapy services. Some Physical Therapy services may also be a habilitative services. Habilitation services are covered under the same terms and conditions applied to rehabilitation services under the Agreement (see the "Rehabilitation and Habilitation Services" section above for details). To be a Covered Service, the therapy must be Medically Necessary. Treatment is covered when provided by a physical, occupational or speech therapist who acts within the scope of their license. Coverage for Physical Therapy and Occupational or Speech Therapy services requires Referral by a Physician. Covered Services include:

- **Physical Therapy** – The treatment by a physical method to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes the use of heat, cold, exercise, electricity, ultraviolet, massage and aquatic therapy (as part of a Physician Therapy treatment plan) to improve circulation, strengthen muscles and encourage return of motion.

- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment.
- **Occupational Therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational Therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Acupuncture** – Treatment by an acupuncturist who acts within the scope of their license using needles along specific nerve pathways to ease pain. All supplies used in conjunction with the acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit.

Infusion Therapy

Physician prescribed Infusion Therapy (each course of therapy must be Medically Necessary).

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

Limitations:

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.

- Drugs labeled "Caution, limited by federal law to Investigational use" or Drugs prescribed for Experimental use.
  - If Anthem determines that the requested Drug, device, procedure, or therapy is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an Independent Medical Review. Refer to INDEPENDENT MEDICAL REVIEW.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges, including the preparation of the finished product, by an Out of Network Provider that exceeds the Prescription Drug Maximum Allowed Amount.
- Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Agreement.

Other Therapy Services

Benefits are available for:

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

percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

If You receive chiropractic services from an Out of Network Provider and You need to submit a claim to us, please send it to the address listed below. If You have any questions or are in need of assistance, please call customer service at **1-855-383-7247**.

American Specialty Health Group (ASHG)
PO Box 509001
San Diego, CA 92150-9001

Transgender Services

Precertification is required for certain Transgender Services (see GETTING APPROVAL FOR BENEFITS for details).

Benefits are provided for services and supplies in connection with Gender Transition when a Physician has diagnosed You with Gender Identity Disorder or Gender Dysphoria. Benefits are provided according to the terms and conditions of this Agreement that apply to all other medical conditions, including Medical Necessity requirements, Precertification and exclusions for Cosmetic Services.

Coverage is provided for specific services according to benefits under this Agreement that apply to that type of service generally, if the Agreement includes coverage for the service in question. If a surgery is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Agreement's Prescription Drug benefits.

Some services are subject to Prior Authorization in order for coverage to be provided. Please refer to GETTING APPROVAL FOR BENEFITS for information on how to obtain the proper reviews.

Transgender Surgery Travel Expense. Certain travel expenses incurred by the Member, up to a maximum $10,000 Anthem payment per transgender surgery or series of surgeries (if multiple surgical procedures are performed), will be covered. All travel expenses are limited to the maximum set forth in the Internal Revenue Code, not to exceed the maximum specified above, at the time services are rendered and must be approved by Anthem in advance.

Travel expenses include the following for the Member and one companion:

- Ground transportation to and from the approved facility when the facility is fifty (50) miles or more from the Member's home. Air transportation by coach is available when the distance is three-hundred (300) miles or more.
- Lodging.

When You request reimbursement of covered travel expenses, You must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call customer service at **1-855-383-7247** for further information and/or to obtain the travel reimbursement form.

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

Transplant Services

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

Urgent Care Services

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

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye.

We cover special contact lenses for aniridia when prescribed by an In Network Physician or In Network Optometrist and up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any Benefit Period to treat aniridia (missing iris) at no charge. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous twelve (12) months

(including when we provided an allowance toward, or otherwise covered, one (1) or more aniridia contact lenses under any other Agreement).

Vision screenings required by Federal law are covered in "Preventive Care" under WHAT IS COVERED – MEDICAL.

Vision Services - Child

Vision Care that is Covered:

The following vision care benefits are available to Members until the last day of the month in which they turn nineteen (19) years of age. We will cover vision care that is listed in this section. See Your SUMMARY OF BENEFITS for the benefit frequencies and Your Cost Share amounts for covered vision care. To get the In Network benefit You must use a Blue View Vision Provider. If You need help finding a Blue View Vision Provider, please visit our website or call us at the number on Your ID card. We will not pay for vision care listed in "Vision Care" under WHAT IS NOT COVERED (Exclusions) – MEDICAL.

Routine Eye Exam

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

Eyeglass Lenses

You have a choice in Your eyeglass lenses. Lenses include factory scratch coating, UV coating, polycarbonate and standard photochromic lenses when received from an In Network Provider at no additional cost. If You choose lens options that are not listed as covered in the SUMMARY OF BENEFITS, You will have to pay all charges for those options.

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

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

Frames

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

Elective Contact Lenses

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

Non-Elective Contact Lenses

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

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

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the Member's vision.

Low vision benefits include:

- Comprehensive Low Vision Exam
- Optical/Non-optical aids
- Supplemental testing.

Please submit appeals regarding Your vision coverage to the following address:

Blue View Vision

555 Middle Creek Parkway

Colorado Springs, CO 80921

WHAT IS NOT COVERED (Exclusions) – MEDICAL

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

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

Benefits will not be given for any illness or injury that is a result of service in the armed forces. This exclusion does not apply to acts of terrorism.

Administrative Charges:

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

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

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

Ambulance: Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non-Covered Services for ambulance include but are not limited to, trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing facility, Physician's office, or Your home.

Breast Reduction/Augmentation: Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes unless it is Medically Necessary.

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

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

Chiropractic Services: Spinal manipulation services are excluded. This includes chiropractic manipulations and/or adjustments as part of a course of chiropractic treatment including but not limited to manipulating the muscle and connective tissue. Services that are otherwise covered under this Agreement that are provided by a Chiropractor acting within the scope of his or her license are covered.

Cosmetic Services: Treatments, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how You look.

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

Counseling Services: Religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy, except for Medically Necessary treatment of a Mental Health condition identified as a "mental disorder" in the DSM IV.

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

Custodial Care, Services/Care Other Facilities: Coverage is not provided for assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine). This

exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice Care, Skilled Nursing Facility or inpatient Hospital care.

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

Dental Services:

Coverage is not provided for:

- Dental care for Members age nineteen (19) and older except as provided for in "Dental Services" under WHAT IS COVERED – MEDICAL.
- Dental Services which the Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if the Member receives a bill or direct charge for Dental Services under any governmental program, then this exclusion shall not apply. Benefits under this Agreement will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving medical assistance.
- Dental Services or health care services not specifically covered under the Agreement (including any Hospital charges, Prescription Drug charges and Dental Services or supplies that do not have an American Dental Association Dental Procedure Code).
- Dental Services completed prior to the date the Member became eligible for coverage.
- Analgesia, analgesia agents, medicines and Drugs for surgical or non-surgical care.
- Local anesthetic when billed separately from a Covered Service, as this is included as part of the final service, such as for restorative services (fillings, crowns).
- Dental Services performed other than by a licensed dentist, licensed Physician, his or her employees.
- Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental Services provided by dentists solely for the purpose of improving the appearance of the tooth when the tooth structure and function are satisfactory and no pathologic conditions (cavities) exist.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restorative (crown, filling) has not been placed.

- Athletic mouth guards, enamel micro abrasion and odontoplasty.
- Bacteriologic tests. Please refer to Your medical coverage to determine if this is a covered medical benefit.
- Cytology sample collection. Please refer to Your medical coverage to determine if this is a covered medical benefit.
- Separate services billed when they are an inherent component of another Covered Service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive purposes.
- Temporomandibular Joint Disorder (TMJ) except as covered under Your medical coverage.
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

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

- Transplant preparation.
- Initiation of immunosuppresives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.
- General anesthesia as listed in “Dental Services,” Dental Services – Pediatric,” “Inpatient Facility Services,” “Outpatient Facility Services” or “Surgery” under WHAT IS COVERED – MEDICAL.

Devices that are:

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

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

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

Drugs, medications or other substances that are:

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

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

Durable Medical Equipment, except as specifically stated in "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" under WHAT IS COVERED – MEDICAL:

- Orthopedic shoes or shoe inserts, except as specifically stated in "Diabetes Equipment, Education and Supplies" and "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" under WHAT IS COVERED – MEDICAL.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.

- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Educational Services: Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Agreement. This exclusion does not apply to the Medically Necessary treatment of Pervasive Developmental Disorder or Autism, to the extent stated in "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" under WHAT IS COVERED – MEDICAL or to diabetes education as stated in "Diabetes Equipment, Education and Supplies" under WHAT IS COVERED – MEDICAL.

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

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

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

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

This exclusion does not apply to services covered in "Clinical Trials" under WHAT IS COVERED – MEDICAL nor to the complications that may arise from non-Covered Services such as Cosmetic Surgery or Experimental Services.

Eyeglasses/Contact Lenses for Prescription, fitting, or purchase of eyeglasses or contact lenses unless specifically stated as a Covered Service in this Agreement or as required by law. Items and services such as eye surgery or contact lenses to reshape the eye for purposes of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition. This exclusion does not apply to Member under age nineteen (19).

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

Foot Care: Coverage is not provided for:

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

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

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

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

Hearing Aids: Hearing aids and hearing tests to determine their efficacy and hearing tests to determine an appropriate hearing aid, except for as stated in "Preventive Care" under WHAT IS COVERED – MEDICAL. This exclusion does not apply to cochlear implants.

Home Care:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider, except for Hospice Care (see "Hospice Care" under WHAT IS COVERED – MEDICAL).
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.

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

Illegal Occupation: Any claim to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation.

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

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

Missed or Canceled Appointments.

Non-Authorized Travel Related to Expenses for mileage, lodging and meals costs, and other Member travel related expenses, except as Authorized by us or specifically stated as a Covered Service in "Center of Medical Excellence (CME) for Transplants and Bariatric Surgery" or "Transgender Services" under WHAT IS COVERED – MEDICAL.

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

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

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

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

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

Non-Licensed Providers: Treatment or services provided:

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

Not Medically Necessary: Any services or supplies which are not Medically Necessary.

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

Orthodontic Services: This includes dental braces, other orthodontic appliances and any related service unless specifically stated as a Covered Service. This exclusion does not apply to Members up to age nineteen (19) or with cleft palate conditions.

Outdoor Treatment Programs and/or Wilderness Programs, unless Medically Necessary.

Over the Counter: Coverage is not provided for Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Agreement or as required by law. See "Family Planning Services" and "Preventive Care" under WHAT IS COVERED – MEDICAL. Also see WHAT IS COVERED – PRESCRIPTION DRUGS.

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

- Air conditioners, humidifiers, air purifiers;

- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility;
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Physician/Other Providers' Charges including:

- Physician or Other Providers' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Physician stand-by charges.

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

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

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

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

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as specifically stated in "Diabetes Equipment, Education and Supplies" under WHAT IS COVERED – MEDICAL or as required by law.

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

This exclusion does not apply to any of the following:

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

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

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

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

Spinal Decompression Devices including, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000. Cervical traction (over door) equipment is not excluded.

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

Teeth (Congenital Anomaly): Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Agreement in the sections “Dental Services” or “Dental Services – Pediatric” under WHAT IS COVERED – MEDICAL or as required by law. This exclusion does not apply to Members under the age nineteen (19).

Teeth, Jawbone, Gums: For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service in “Dental Services” and “Dental Services – Pediatric” under WHAT IS COVERED – MEDICAL.

Telephone/Internet consultations: For telephone consultations or consultations via electronic mail or internet/website, except as required by law or specifically stated as a Covered Service. See “Telehealth” under WHAT IS COVERED – MEDICAL.

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

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

- Gastric electrical stimulation.
- Hippotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

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

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

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

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

- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Agreement.
- For orthoptics or vision training and any associated supplemental testing.
- For two (2) pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Agreement.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- Oversize lenses.
- For sunglasses.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames or contact lenses purchased outside of our formulary.

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

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

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

Workers' Compensation: Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law.

WHAT IS COVERED – PRESCRIPTION DRUGS

Administered by a Medical Provider

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

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

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

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

Note: Your Copayments and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager from Drug manufacturers, wholesalers, distributors, and/or

similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy benefits manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to quarterly review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request by calling the number on the back of Your identification card and at **www.anthem.com/ca**. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List. See "How to Obtain a Drug not on the Formulary" below for information about obtaining a non-Formulary exception.

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

If You have a question regarding whether a Drug is on the Prescription Drug List, please call toll free **1-855-383-7247**.

How to Obtain a Drug not on the Formulary

Your Prescription Drug Benefit covers those Drugs listed on our Prescription Drug List. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the Prescription Drug List for other Anthem products. **In cases where Your Physician prescribes a medication that is not on the Anthem Select Drug List, it may be necessary to obtain a non-Formulary exception in order for the Prescription to be a covered benefit. Your Physician must complete a non-Formulary exception**

form and return it to us. You or Your Physician can get the form online at www.anthem.com/ca or by calling 1-855-383-7247. If Your non-Formulary exception request is for a non-Specialty medication and we approve Your request, the amount You pay will be equal to a Tier 3 cost share. If Your non-Formulary exception request is for a Specialty medication and we approve Your request, the amount You pay will be equal to a Tier 4 cost share.

You or Your Physician may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if You are suffering from a health condition that may seriously jeopardize Your life, health or ability to regain maximum function or if You are undergoing a current course of treatment using a Drug not covered by the Plan. We will make a coverage decision within 24 (twenty-four) hours of receiving Your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, You have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 (twenty-four) hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of Your request or Your Physician's request for an exception will only be provided if You are a Member enrolled under the Plan.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the Pharmacy Benefit Manager's (PBM) Home Delivery Pharmacy;
- Specialty Drugs;
- Self-Administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin, including syringes;

- Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
- Contraceptives, including oral contraceptive Drugs, injectable contraceptive Drugs, contraceptive patches, and contraceptive rings, including over the counter FDA-approved contraceptive methods as prescribed by a health care Provider. Certain contraceptives are covered under the medical benefits, including the specific eighteen (18) FDA approved contraceptive methods. Please see "Preventive Care" under WHAT IS COVERED – MEDICAL for more details;
- Flu Shots (including administration);
- AIDS vaccine (when approved);
- Appropriate pain management medications for terminally ill patients;
- Weight loss Drugs when Medically Necessary for the treatment of morbid obesity (See WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for exclusions);
- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the Compound Drug are FDA approved and require a prescription to dispense, and it is not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Retail or Home Delivery (Mail Order) Pharmacy

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

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

If our records show that You may be using Prescription Drugs, such as narcotics, anxiolytics, skeletal muscle relaxants, sedative hypnotics and/or amphetamines, in a harmful or abusive manner, or with harmful frequency, we will inform You in writing that if You continue to use Prescription Drugs in this manner, You may be enrolled in our Pharmacy Home Program. This letter will also tell You how to appeal our assessment. The Pharmacy Home Program uses a single Pharmacy, known as Your Pharmacy Home, to provide and coordinate all of Your Pharmacy services for the next twelve (12) months and benefits will only be paid if You use Your Pharmacy Home. If review of our records sixty (60) days after the above notification shows that use of a single In Network Pharmacy is still needed, we will notify You of the date You will be enrolled in the Pharmacy Home Program and provide You with a list of Pharmacies from which to select an In Network Pharmacy Home within fifteen (15) days. We will also inform You how You can appeal our decision. If You do not select an In Network Pharmacy within fifteen (15) days, we will select a Pharmacy Home for You. You will be given thirty (30) days from our notice of enrollment to appeal our decision before Your enrollment in a Pharmacy Home becomes effective. (For more information regarding appealing our decision, please see COMPLAINTS AND GRIEVANCES.) If You are enrolled in the Pharmacy Home Program, we will review our decision in twelve (12) months and notify You that we have discontinued Your enrollment in the Pharmacy Home Program if the review shows that You are not using Prescription Drugs in a harmful or abusive manner. If You have an Emergency, we will exempt You from the Pharmacy Home Program for at least seventy-two (72) hours. You may be removed from the Program if it is Medically Necessary for You to use more than one (1) Pharmacy or if Your Physician requests that You be removed from the Program.

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

Helpful tip: Benefits for Prescription Drugs, including Specialty Drugs, which must be administered to You in a medical setting (e.g., Physician's office, home care visit, or outpatient Facility) are covered in "Centers for Medical Excellence (CME) for Transplants and Bariatric Surgery," "Home Care Services," "Inpatient Facility Services," "Office Visits," "Office Visits – Additional Services in an Office Setting," "Outpatient Facility Services," "Skilled Nursing Facility," "Therapy Services" or "Urgent Care Services" under WHAT IS COVERED – MEDICAL. Please read those sections for important details.

Maintenance Medication - Home Delivery Pharmacy

If You are taking a Maintenance Medication, You may get the first thirty (30) day supply plus one additional thirty (30) day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must contact the Home Delivery Pharmacy before the second refill and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. After starting a Maintenance Medication, You will have up to sixty (60) days to register Your choice of where You would like to obtain Your Maintenance Medication. If You do not register Your choice of where You would like to obtain Your Maintenance Medication each Year through the Home Delivery Pharmacy, You will have to pay the full retail cost of any Maintenance Medication until You register. You can tell us Your choice by phone at **1-855-383-7247** or by visiting our website at **www.anthem.com/ca**.

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

Specialty Drugs are only covered when purchased through a Specialty Preferred Provider. Please see "Specialty Preferred Pharmacy" below for more information.

Helpful Tip: If You decide to use Home Delivery, we suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery Prescription Drug program, You can call customer service toll-free at **1-855-383-7247**.

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, injectables, including Self-Administered Injectables except Insulin. Please check with the Home Delivery Prescription Drug program customer service department at **1-855-383-7247** for availability of the Drug or medication.

Specialty Preferred Pharmacy

Specialty Drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty Drugs may require nursing services or special programs to encourage patient compliance. **Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.**

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

When You Order Your Prescription Through the Specialty Preferred Provider

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

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

You or Your Physician may order Your Specialty Drug from the Specialty Preferred Program by calling **1-855-383-7247**. The Specialty Preferred Provider has dedicated care coordinators to help You take charge of Your health problem and offers toll-free twenty-four (24) hour access to nurses and pharmacists to answer Your questions about Specialty Drugs. A dedicated care coordinator will work with You and Your Physician to get Prior Authorization. When You call the Specialty Preferred Provider, a dedicated care coordinator will guide You through

the process up to and including actual delivery of Your Specialty Drug to You. When You order Your Specialty Drug by telephone, You will need to use a credit or debit card to pay for it. You may also submit Your Specialty Drug Prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Coinsurance as found Your SUMMARY OF BENEFITS. When You order Your Specialty Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

You or Your Physician may obtain a list of Specialty Drugs available through the Specialty Preferred Provider by contacting Member Services by calling toll free **1-855-383-7247** or online at **www.anthem.com/ca**. You or Your Physician may also obtain order forms by contacting Member Services or by accessing our website at **www.anthem.com/ca**.

How to obtain an exception to the Specialty Pharmacy Program

If You believe that You should not be required to get Your Specialty Drug through the Specialty Pharmacy Program, You or Your Physician must complete an exception to the Specialty Pharmacy Program form to request an exception and send it to us. The form can be mailed or faxed to us. If You need a copy of the form, You may call us at **1-855-383-7247** to request one. You can also get the form online at **www.anthem.com/ca**. If we have given You an exception, it will be in writing for the approved amount of time as medically appropriate. If You believe that You still should not be required to get Your medication through the Specialty Pharmacy Program, when Your prior exception approval expires, You must again request an exception. If we deny Your request for an exception, it will be in writing and will tell You why we did not approve the exception.

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

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

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

Important Details about Prescription Drug Coverage

Your Prescription Drug coverage includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Physician may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

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

Drug Utilization Review

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

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your Physicians about alternatives to certain prescribed Drugs. We may contact You and Your Physician to make You aware of these choices. Only You and Your Physician can determine if the therapeutic substitute is right for You. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call customer service at the phone number on the back of Your identification card.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact Your Provider to get the details we need to decide if Prior Authorization should be given. We will give the results of our decision to both You and Your Provider. Members must use the Prior Authorization process outlined here to request coverage for medications not on the Anthem Select Drug List.

Your Physician may submit a Prior Authorization form to Anthem. This form is available by calling **1-855-383-7247**, online at **www.anthem.com/ca** or by contacting the Specialty Preferred Provider at **1-855-383-7247** (see "How to obtain an exception to the Specialty Pharmacy Program" above). You may call customer service at **1-855-383-7247** to ask that a Prior Authorization form be faxed to Your Physician. If Your request is urgent, Anthem offers a seventy-two (72) hour override for California Members to receive three (3) days of their medication. Your Physician may also request the seventy-two (72) hour override.

You may need to try a Drug other than the one originally prescribed if we determine that it should be clinically effective for You. However, if we determine through the Prior Authorization process that the Drug originally

prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring Prior Authorization will be provided to You after You make the required Copayment. (If, when You first become enrolled, You are already being treated for a medical condition with a Drug that has been appropriately prescribed and is considered safe and effective for Your medical condition and You underwent a Prior Authorization process under a prior plan which required You to take different Drugs, we will not require You to try a Drug other than the one You are currently taking.)

The Prior Authorization review process is outlined below:

- The PBM handles the first review.
    - If the Anthem defined criteria is met, the PBM will communicate to the Physician and Member about length of time and approval provided.
    - If the Anthem defined criteria is NOT met, the PBM will communicate to the Physician and Member about the denial.
        - The letters contain steps for additional review including information about filing a Grievance.
        - In some cases, a secondary review is handled by the Medical Reviewers at Anthem if additional medical justification needs to be established.
- For Pain Management requests for terminally ill patients, if a request is denied or more information is required, the Provider will be contacted within one working day of that determination. The requested treatment will be authorized if this timeframe expires.
- Anthem medical reviewers handle the second review.
    - This review may require or include Physician peer-to-peer discussion and additional documentation prior to final decision.
    - Any decision is communicated to both Physician and Member along with our standard Grievance process for the Member to use if needed.
- How to file a claim for reimbursement for Medically Necessary Prescription Drugs if payment is denied at the Pharmacy due to failure to obtain Prior Authorization (further details can be found in “How to file medical claims” and “How to send a member claim form” under IMPORTANT INFORMATION ABOUT THIS AGREEMENT):
    - Provide Anthem with a Notice of Claim and member claim form.
    - The member claim form can be found online at **www.anthem.com/ca** or requested by calling customer service at **1-855-383-7247**.

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

  Anthem Blue Cross

  P.O. Box 60007

  Los Angeles, CA 90060-0007

If Prior Authorization is denied You have the right to file a Grievance as outlined under COMPLAINTS AND GRIEVANCES and INDEPENDENT MEDICAL REVIEW.

For a list of Drugs that need Prior Authorization, please call **1-855-383-7247** or visit **www.anthem.com/ca**. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or Generic Drugs are covered under the Prescription Drug coverage.

Step Therapy

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

Additional Features

Day Supply and Refill Limits

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

Half-Tablet Program

The Half-Tablet Program lets You pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets You get a thirty (30) day supply (fifteen (15) tablets) of the higher strength Drug when the Physician tells You to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and You should talk to Your Physician about the choice when it is available. To get a list of the Drugs in the program call **1-855-383-7247**.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at our Specialty Pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. This program allows You to get Your Prescription Drug in a smaller quantity and at a prorated Copayment so that if Your dose changes or You have to stop taking the Prescription Drug, You can save money by avoiding costs for Prescription Drugs You may not use. You can access the list of these Prescription Drugs by calling the toll-free customer service number on Your identification card or log on to our website at **www.anthem.com/ca**.

Special Programs

Except where prohibited by Federal Regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, we may allow access to network rates for Drugs not listed on our Formulary.

Claims and Member Service

For information and assistance, the Member may call customer service at **1-855-383-7247** or write us at:

Anthem Blue Cross

Anthem Prescription Drug Program

P.O. Box 4165

Woodland Hills, CA 91365-4165

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

WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS

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

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

An allergenic extract or vaccine.

Note: Allergenic extract or vaccine is covered in "Office Visits" and "Office Visits – Additional Services in an Office Setting" under WHAT IS COVERED – MEDICAL.

Clinically-equivalent alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined to be Medically Necessary.

Compound Drugs unless all the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

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

Drugs over quantity limits: Drugs in quantities which are over the limits set by Anthem.

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

Drugs that do not need a Prescription: Drugs that do not need a Prescription by federal law (including Drugs that need a Prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter Drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a Physician.

Drugs used for cosmetic purposes.

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

Note: Durable Medical Equipment (DME) is covered in "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" under WHAT IS COVERED – MEDICAL.

Lost or stolen Drugs: Stolen Drugs or refills of lost Drugs (excluding those from Home Delivery (Mail Order) Pharmacy or Specialty Pharmacy).

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

Non-approved Drugs: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the United States but are not approved by the FDA.

Off label use: Off label use is covered, as long as it meets the following criteria:

1. The Drug is FDA-approved.
2. a. The Drug is prescribed for the treatment of a life-threatening condition; or
   b. The Drug is prescribed for treatment of a chronic and seriously debilitating condition, is medically necessary to treat that condition, and is on the Formulary. If the Drug is not on the Formulary, the request for coverage shall be considered pursuant to H&SC § 1367.24.
3. The Drug has been recognized for treatment of that condition by any of the following:
   a. The American Hospital Formulary Service's Drug Information;
   b. One of the following compendia, if recognized by the federal C enters for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
      i. The Elsevier Gold Standard's Clinical Pharmacology;
      ii. The National Comprehensive Cancer Network Drug and Biologics Compendium;
      iii. The Thomson Micromedex DrugDex. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. Any medically necessary services associated with the administration of a Drug are also covered.

Onchomycosis Drugs: Drugs for Onchomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.

Over the counter Drugs, devices or products are not Covered Services.

Over the counter items: Drugs, devices and products, or Prescription Drugs with over the counter equivalents except for prescribed contraceptives with over the counter equivalents and for over the counter Drugs recommended by the U.S. Preventive Service Task Force when prescribed by a health care Provider.

Prescription Drugs used to treat Infertility.

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

Weight loss Drugs: Weight loss Drugs unless Medically Necessary for treatment of morbid obesity.

Note: Medically Necessary weight loss Drugs are covered in "Covered Prescription Drugs" under WHAT IS COVERED – PRESCRIPTION DRUGS

ALTERNATIVE BENEFITS

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

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

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

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

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

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

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

DUPLICATION OF ANTHEM BENEFITS

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

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

THIRD PARTY LIABILITY

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

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

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions)

Below is important information regarding this Agreement.

Benefits not transferable: You are the only person entitled to receive benefits under this Agreement. FRAUDULENT USE OF SUCH BENEFITS CAN RESULT IN TERMINATION OF THIS AGREEMENT AND APPROPRIATE LEGAL ACTION MAY BE TAKEN.

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

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

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

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

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

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

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact customer service at **1-855-383-7247**. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

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

to continue that Provider's services. If You disagree with our determination regarding continuation of care, please refer to INDEPENDENT MEDICAL REVIEW.

Coordination of Dental Benefits: Coordination of Benefits (COB) provisions apply when You or members of Your family have other coverage through another plan that offers dental benefits. When You have other dental coverage, both plans will work together to provide the maximum dental benefits for which You are entitled. Coordinated benefits will never be less than those normally provided under this plan. This provision is only applicable to the dental benefits found in "Dental Services – Child" under WHAT IS COVERED – MEDICAL.

If You are eligible for dental benefits through two or more plans, one of the plans will be responsible for "primary coverage." This means full benefits will be provided by the primary coverage before benefits of the other plan will be provided.

A plan determined to be secondary shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out of pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

1. If You have Pediatric Essential Health Benefits that are included as part of Your medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary coverage.
2. If the spouses both have separate dental plans, each offering coverage for spouse and family the plan that covers the person other than as a Dependent (for example, as an employee, Member, Subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a Dependent is the secondary plan.
3. If the Subscriber is the same person on each plan, the plan under which he or she has been enrolled for the longer period of time will be primary.
4. If one of the plans does not have a COB provision, it will be primary carrier.
5. As required by law, if a covered Member of Your family also has coverage under Medicaid, this plan is always primary.
6. If Dependent children are covered under both plans, one of the following rules will apply, unless there is a court order stating otherwise:
    a. The plan covering the parent with the earlier birthday in the Year will be primary. If both parents have the same birthday, the plan covering the Dependent for the longer period of time will be primary; OR
    b. Some insurance companies always designate the father's plan as the primary carrier for children. If Anthem must coordinate benefits with a company that has that rule, the father's policy will be primary. You will be asked to complete questionnaires from time to time asking about other dental coverage. Please complete

and return the questionnaire quickly and let us know when other insurance coverage changes or is terminated to avoid possible claims denials.

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

- **Notice of Claim & Submission of Claims:** After you get Covered Services, we must receive written notice of your claim within ninety (90) days, or as soon thereafter as reasonably possible.

  Either the Subscriber or Provider of service must claim benefits by sending us properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by us within fifteen (15) months from the date the services or supplies are received. We will not be liable for benefits if we do not receive completed claim forms within this time period. Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available by accessing our web site at **www.anthem.com/ca**, by calling the telephone number on the back of Your identification card or by writing to us at the address in the next sentence. Claims should be submitted to **Anthem, P.O. Box 60007, Los Angeles, CA 90060-0007**.

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

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

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

Anthem Blue Cross

P.O. Box 60007

Los Angeles, CA 90060-0007

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

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

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

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

Medical Policy and Technology Assessment: Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately twenty (20) doctors from various medical specialties including Anthem's medical directors, doctors in academic medicine and doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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

P.O. Box 9051

Oxnard, California 93031-9051

Payment Innovation Programs: We pay Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) - may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and You do not share in any payments made by Network Providers to us under the Program(s).

Payment to Providers and Provider reimbursement: Benefits for In Network Providers are based on the Maximum Allowed Amount. In Network Providers have an agreement in effect with us and have agreed to accept the Maximum Allowed Amount as payment in full. You will not be required to pay any In Network Provider for amounts owed to that Provider by us (excluding Deductible, Copayments/Coinsurance, and services or supplies that are not a covered benefit of the Plan), even in the unlikely event that we fail to pay the Provider. We pay the benefits of this Plan directly to In Network Hospitals, In Network Physicians, medical transportation Providers, certified nurse midwives, registered nurse practitioners and other In Network Providers, whether You have authorized assignment of benefits or not.

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

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out of Network Providers could be balanced billed by the Out of Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

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

Receipt of information: We are entitled to receive from any Provider of service information about You that is necessary to administer claims on Your behalf according to federal/State law. This right is subject to all applicable confidentiality requirements. You agree to assist in obtaining this information if needed. Failure to assist us in obtaining the necessary information when requested may result in the delay or rejection of Your claims until the necessary information is received by us.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact us at **1-855-383-7247** for a copy of our policies and procedures for preserving Your medical record confidentiality.

Relationship of Parties: The relationship between Anthem and In Network Providers is an independent contractor relationship. In Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In Network Providers.

Your health care Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by You while receiving care from any In Network Provider or for any injuries suffered by You while receiving care from any In Network Provider's Facilities.

Your In Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In Network Providers, Out of Network Providers and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or us.

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

Submission of Claims: Either the Subscriber or Provider of service must claim benefits by sending Anthem properly completed claims forms itemizing the services or supplies received and the charges. These claim forms must be received by Anthem within fifteen (15) months from the date of services or supplies are received. Anthem

will not be liable for benefits if a completed claim form is not furnished to Anthem within this time period, except in the absence of legal capacity. Claims forms must be used, canceled checks or receipts are not acceptable.

Terms of coverage:

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

Time of payment of claim: Any benefits determined to be due under this Agreement shall be paid within thirty (30) working days after we receive a complete written proof of loss and determination that benefits are payable. A claim together with all additional information reasonably necessary to determine our obligation under this Agreement and reasonable access to information concerning Provider services is required. Information necessary to determine our obligation under this Agreement claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for us to determine the Medical Necessity for the health care services provided.

Value-Added and Incentive Programs: We may offer health or fitness related programs and products to our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on Pharmacy products (over the counter Drugs, consultations and biometrics).

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Agreement and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, we may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

Voluntary Clinical Quality Programs: We may offer additional opportunities to assist You in obtaining certain covered Preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your Plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which we encourage You to use for Health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card results in taxable income to You, we recommend that You consult Your tax advisor.)

Workers' compensation insurance: This Agreement does not take the place of or affect any requirement for or coverage by workers' compensation insurance. Additionally, as stated under WHAT IS NOT COVERED (Exclusions) – MEDICAL, this Agreement does not cover any condition for which benefits are covered by any worker's compensation law or similar law.

COMPLAINTS AND GRIEVANCES

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

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

Anthem Blue Cross
Attn: Customer Service Department
P.O. Box 9051
Oxnard, CA 93031-9051

For Dental Services for Members through age eighteen (18), please address Your correspondence to:

Anthem Blue Cross
P.O. Box 1122
Minneapolis, MN 55440-1122

For Vision Services for Members through age eighteen (18), please address Your correspondence to:

Blue View Vision
555 Middle Creek Parkway
Colorado Springs, CO 80921

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

If You are dissatisfied and wish to file a Grievance, You may request a copy of the Grievance form to complete and return to us. You may also ask the customer service representative to complete the form for You over the telephone. You may also submit a Grievance form online in the "Members" section at **www.anthem.com/ca**. You must submit Your Grievance to us no later than one-hundred eighty (180) days following the date You receive a denial notice from us or any other incident or action with which You are dissatisfied. You must include all pertinent

information from Your identification card and the details and circumstances of Your concern or problem. Upon receipt of Your Grievance, Your issue will become part of our formal Grievance process and will be resolved accordingly.

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

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

Department of Managed Health Care

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

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

INDEPENDENT MEDICAL REVIEW

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

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

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

Within three (3) business days of our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review (and within 24 hours of approval of the request for review involving an imminent and serious threat to the health of the Member), we will provide the independent medical review organization designated by the Department with: A copy of all relevant medical records and documents for review, and any information submitted by the Member or the Member's Physician. Additionally, any newly developed

or discovered relevant medical records identified by us or our In Network Providers after the initial documents are provided will immediately be forwarded to the independent medical review organization.

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

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

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

Independent Medical Review of Grievances involving a Disputed Health Care Service

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

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

Eligibility

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

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

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

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

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

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

BINDING ARBITRATION

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

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

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

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

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

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless You and Anthem Blue Cross agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross

P.O. Box 9086

Oxnard, CA 93031-9086

DEFINITIONS

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

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

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

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

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

Anthem Blue Cross ("Anthem") means Blue Cross of California, doing business as Anthem Blue Cross, a health care service plan regulated by the Department of Managed Health Care. In this Agreement, the words "we," "us," "our," and "Anthem" refer to Anthem Blue Cross.

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

1. there is no In Network Physician who practices in the appropriate specialty or there is no Contracting Hospital which provides the required services or has the necessary Facilities,
2. that meet the adequacy and accessibility requirements of State or federal law and
3. the Member is referred to Hospital or Physician that does not have an agreement with Anthem for a Covered Service by an Anthem In Network Physician.

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

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

Authorized Service(s): A Covered Service You get from an Out of Network Provider that we have agreed to cover at the In Network level. Anthem may Authorize such service(s) when a service is not available from an In Network Provider within the Plan's applicable access standards.

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

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

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

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

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

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

Compounded (combination) Medications (Compound Drug) is when one or more ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a Drug manufacturer.

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

Copayment is a fixed amount (for example $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service.

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

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

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

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

Deductible means the amount of charges You must pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Agreement. Your Deductible is stated in Your SUMMARY OF BENEFITS. The Prescription Drug Deductible may be separate from the Medical Deductible and may or may not accumulate towards satisfying the Medical In Network or Out of Network Provider Deductibles. Additional information is available under YOUR PAYMENT RESPONSIBILITY.

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

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

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

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

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

Domestic Partner or Domestic Partnership are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. Further, they must have either filed a Declaration of Domestic Partnership with the Secretary of State of the State of California in accordance with Section 298.5 of the Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created. A Domestic Partner must meet the eligibility requirements for Domestic Partners outlined under YOUR ELIGIBILITY.

Drugs means Prescription Drugs.

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

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

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

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

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

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

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

Family Plan means a Plan in which the Subscriber is enrolled with one or more Dependents. For additional information on Newborns during the first sixty (60) days from birth and Adopted Children during first sixty (60) days from the date the Subscriber, enrolled spouse, or enrolled Domestic Partner is granted the right to control health care for an Adopted Child, refer to YOUR ELIGIBILITY.

Formulary means a listing of Prescription Drugs that are determined by Anthem to be designated as Covered Drugs. The list of approved Prescription Drugs developed by Anthem in consultation with Physicians and pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription

Drugs and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Prescription Drugs coverage. This list is subject to quarterly review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at **www/anthem.com/ca**.

Gender Identity Disorder (Gender Dysphoria) (GID) is a formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Transition is the process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

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

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

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

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

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

outpatient services according to State and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations.

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

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

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

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

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

In Network (Tier 2) Hospital is a Hospital that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Member through negotiated payment arrangements under this Plan. Member financial responsibility for Covered Services will be less when obtain services are obtained from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital.

In Network Pharmacy is a Pharmacy that has an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. To find an In Network Pharmacy near You call customer service at **1-800-700-2533**.

In Network Provider is a Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Member through negotiated payment arrangements under this Plan.

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

Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call customer service at **1-855-383-7247** or check our website at **www.anthem.com/ca** for more details.

Maximum Allowed Amount for this Plan is the maximum amount of reimbursement we will allow for Covered Services and supplies. See "Maximum Allowed Amount" under HOW YOUR COVERAGE WORKS.

Medical Emergency means a Psychiatric Emergency Medical Condition or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity including, without limitation, sudden and unexpected severe pain that the absence of immediate medical or psychiatric attention could reasonably result in:

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

Medically Necessary and Medical Necessity services are procedures, treatments, supplies, devices, equipment, Facilities or Drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:

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

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors. In evaluating new technology and whether to consider it as

eligible for coverage under our Agreement, we consider peer-reviewed medical literature, consultations with Physicians, Specialists and other health care professionals, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

Member shall mean both the Subscriber and all other Dependents who are enrolled or automatically enrolled for coverage under this Agreement.

Mental Health and Substance Abuse. Mental Health includes conditions that constitute Severe Mental Illness and Serious Emotional Disturbances of a Child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any Mental Health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance Abuse means drug or alcohol abuse or dependence.

Mental Health includes Severe Mental Illness and Serious Emotional Disturbances of a Child.

Minimum Essential Coverage: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

Monthly Premium Due Date is the first day of the Agreement period for which the Premium is paid.

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

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

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

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

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

Other Eligible Providers do not enter into agreements with us. These Providers include:

- blood bank,
- dentist (D.D.S.),
- dispensing optician.

Other Practitioners include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Works, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners designated by law.

Out of Network Pharmacy is a Pharmacy that does not have an In Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out of Network Pharmacy.

Out of Network Provider is a Provider that does **not** have an agreement or contract with us or our subcontractor(s) to give services to our Members through negotiated payment arrangements under this Plan. You will often get a lower level of benefits when You use Out of Network Providers.

Out of Pocket Maximum: A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the SUMMARY OF BENEFITS. Such expense does not include charges in excess of the Maximum Allowed Amount, Reasonable and Customary Value or any non-Covered Services. Refer to the SUMMARY OF BENEFITS for other services that may not be included in the Out of Pocket Maximum. When the Out of Pocket Maximum is reached, no additional Deductible, Copayment or Coinsurance is required unless otherwise specified in this Agreement.

Pharmacy means a licensed retail or home delivery (mail order) Pharmacy.

Pharmacy Benefits Manager (PBM) is a Pharmacy benefits management company with which Anthem contracts to manage Pharmacy benefits. Anthem's Pharmacy Benefits Manager has a nationwide network of retail Pharmacies, a mail service Pharmacy, and clinical services that include Formulary management.

The management and other services the Pharmacy Benefits Manager provides include, but are not limited to: managing a network of retail Pharmacies and operating a mail service Pharmacy. Anthem's Pharmacy Benefits Manager, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

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

Physician means a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

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

Preferred In Network (Tier 1) Hospital is a Hospital that has entered into a Preferred In Network agreement with Anthem. A list of Preferred In Network (Tier 1) Hospitals is available upon request from our customer service representatives. Member financial costs may be less when services are obtained from a Preferred In Network (Tier 1) Hospital compared to an In Network (Tier 2) Hospital. For assistance locating a Preferred In Network (Tier 1) Hospitals or In Network Providers, You may contact us at **1-855-383-7247** or access our website at **www.anthem.com/ca**.

Premium is the monthly charge You must pay Anthem to establish and maintain coverage under this Agreement. Premium may also be referred to as Subscription Charge.

Premium Payment(s) means monthly Premium received by Anthem that has been approved by Your financial institution. If funds are not approved by Your financial institution, they are not considered received and this Agreement may be terminated for non-payment of Premium. Refer to YOUR ELIGIBILITY for additional information about termination when You do not pay Premiums.

Prescription means a written order issued by a Physician.

Prescription Drug (also referred to as legend) means a medicine that is that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a Prescription." This includes the following:

1. Compounded (combination) medications, when one or more ingredients are FDA-approved, require a prescription to dispense and is not essentially the same as an FDA-approved product from a Drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

Prescription Drug Maximum Allowed Amount is the maximum amount we allow for Prescription Drugs. The amount is determined by Anthem using cost information provided to by the Pharmacy Benefits Manager. The Prescription Drug Maximum Allowed Amount is subject to change.

Primary Care Physician (PCP) is a Physician who gives or directs health care services for You. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Provider is a professional or Facility licensed by law that gives health care services within the scope of that license or is permitted by California law to provide health care services and is approved by us. Providers that deliver Covered Services are described throughout this Agreement. If You have a question about a Provider not described in this Agreement please call customer service at **1-855-383-7247**.

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

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

Reasonable and Customary Value

1. For professional Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of a third party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered;
2. For Facility Out of Network Providers, the Reasonable and Customary Value is determined by using a percentile of billed charges from a database of Anthem's actual claims experience, subject to certain thresholds based on

each Provider's cost-to-charge ratio as reported by the Provider to a California governmental agency and the actual claim submitted to us.

Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to create a normal appearance, to extent possible.

Residential Treatment Center is an inpatient treatment Facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Health or Substance Abuse condition. The Facility must be licensed to provide psychiatric treatment of Mental Health or Substance Abuse conditions according to State and local laws and requires a minimum of one (1) Physician visit per week in the Facility. Wilderness programs are not considered Residential Treatment Centers.

Self-Administered Drugs means Drugs that are administered which do not require a medical professional to administer.

Serious Emotional Disturbances of a Child or adolescent (minors under the age of eighteen (18)) is the presence of one (1) or more "mental disorders" as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norm. The child must also meet one (1) or more of the following criteria: 1) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: a) self-care, b) school functioning, c) family relationships, or d) ability to function in the community, and either the child is at risk of being removed from the home or has already been removed from the home, or the mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment; 2) the child displays one of the following: a) psychotic features, b) risk of suicide, or c) risk of violence; 3) the child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of Education Code and is determined to have an emotional disturbance as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

Severe Mental Illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, Pervasive Developmental Disorder or autism, anorexia nervosa (includes nutritional counseling) and bulimia nervosa (includes nutritional counseling).

Service Area is the geographic area within the State of California within which this Agreement is offered and issued.

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.

Specialist (Specialty Care Physician or SCP): A Specialist is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. Specialists include Physicians with specialties in allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, an surgical specialty, otolaryngology, urology and others designated by law.

Specialty Drugs means Drugs that are high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision, training and monitoring of their effect on the patient's Drug therapy by a medical professional. These Drugs often require special handling, such as temperature-controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies. Specialty Drugs are required to be obtained through the Specialty Preferred Pharmacy unless stated otherwise. Specialty Drugs may be placed on Drug Tiers 1, 2, 3 or 4.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "Stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

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

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at an originating site and the health care Provider is at a distant-site. Telehealth facilitates patient self-management and caregiver support for patients and includes real-time interactions and the transmission of a patient's medical information from an originating site to the distant site without the presence of the patient. The originating site and the distant-site are licensed to provide Telehealth according applicable law.

Tier 1 Drugs include most Generic Drugs and low-cost preferred Brand Drugs.

Tier 2 Drugs include non-preferred Generic Drugs, preferred Brand Drugs or those Drugs recommended by Anthem's pharmaceutical and therapeutics (P&T) committee based on Drug safety, efficacy and cost.

Tier 3 Drugs include non-preferred Brand Drugs; those Drugs recommended by Anthem's pharmaceutical and therapeutics (P&T) committee based on Drug safety, efficacy and cost; or those Drugs generally that have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4 Drugs include those Drugs with FDA or Drug manufacturer limits on distribution to Specialty Pharmacies, self-administered Drugs requiring training or clinical monitoring, those Drugs manufactured using biotechnology or those Drugs that cost the Plan more than $600 (net of rebates).

Urgent Care is not an Emergency, but an unexpected illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care.

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

You and Your means the Subscriber and any Dependents covered under this Agreement.

HOW TO CONTACT US

If You have any questions about the information provided, please feel free to contact us.

For information about…	Contact	Phone Number	Address
Enrollment	Membership	**1-855-383-7247**	**Anthem Blue Cross P.O. Box 9051 Oxnard, CA 93031-9051**
Medical Benefits & Claims	Claims	**1-855-383-7247**	**Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007**
Hearing and Speech Impaired Customer Service	Customer Service	**TTY 1-877-206-4966**	
Precertification	Medical Management	**1-800-274-7767**	

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

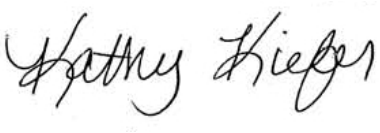
- Locate Preferred In Network Hospitals and In Network Providers
- Check status of Your claims and download claim forms
- Access health content and tools from WebMD®
- Review Your health insurance Plan's benefits and special offers
- Learn about Pharmacy benefits and Your Plan's Health Programs

If You want secure access to all the features the website has to offer, log onto **www.anthem.com/ca**, select "Members" and follow the prompts for registering. If You opted to receive Your contract materials electronically, this is also the link to use to view that information (if applicable). You will need Your Anthem ID number, which is located on Your health identification card.

This Agreement is subject to all the definitions, limitations, exclusions and conditions as stated herein. Authorized officers of Anthem Blue Cross have approved this Agreement.

ANTHEM BLUE CROSS

J. Brian Ternan
President
Anthem Blue Cross



Kathy Kiefer
Secretary
Anthem Blue Cross

HOW TO CONTACT US

APPENDIX I – MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving health care. As Your health care partner, we want to make sure Your rights are respected while providing Your health benefits. That means giving You access to our network of health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect us to keep Your personal health information private by following our privacy policies and State and federal laws.
- Get the information You need to help make sure You get the most from Your health Plan and share Your feedback. This includes information on:
  - our company and services,
  - our network of health care Providers,
  - Your rights and responsibilities,
  - the rules of Your health Plan,
  - the way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You get,
  - any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without it having an affect on any care You may get in the future. This includes asking Your doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.

- Choose an In Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems, as well as You can, and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give us, Your doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with to Your coverage with us.
- Inform customer service if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments or would like to contact us, please go to **www.anthem.com/ca** and select Customer Support > Contact Us. Or call the number on Your ID card or customer service at **1-855-383-7247**.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the Plan are overseen by the Subscriber Agreement, Member Handbook or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

APPENDIX II –SUBSCRIBER AND PREMIUM INFORMATION

Issued by
ANTHEM BLUE CROSS

AGREEMENT NAME:
PROVIDER NETWORK:
[FORMULARY:]
CONTRACT CODE:
SUBSCRIBER'S NAME:
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
[DEPENDENT'S NAME:]
SUBSCRIBER'S [RESIDENTIAL]ADDRESS
MONTHLY PREMIUM:
PREMIUM RATE EFFECTIVE DATE:
Please review this information carefully and if it is incorrect please inform Your agent or Anthem immediately.