Combined Evidence of Coverage and Disclosure Form

Anthem Minimum Coverage EPO

49ZK



An Exclusive Provider Organization (EPO) Plan

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

1-855-634-3381

RIGHT TO EXAMINE

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.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Welcome to Anthem!

We are pleased that You have become a Member of Our health plan, where it is Our mission to improve the health of the people We serve. We have designed this Evidence of Coverage and Disclosure Form (EOC) (also called Agreement or Plan) to give a clear description of Your benefits, as well as Our rules and procedures.

This EOC 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 EOC are related. Therefore, reading just one (1) or two (2) sections may not give You a full understanding of Your coverage. You should read the whole EOC to know the terms of Your coverage.

This EOC, the application and any endorsements attached shall constitute the entire Agreement under which Covered Services and supplies are provided by Us.

Many words used in the EOC have special meanings (e.g., Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this EOC You will also see references to "We," "Us," "Our," "You" and "Your." The words "We," "Us," and "Our" mean Anthem Blue Cross (Anthem). The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

Should You have a complaint, problem or question about Your health Plan or any services received, a Member Services representative will assist You. Contact Member Services by calling the number on the back of Your Member Identification Card. Also be sure to check Our web site, www.anthem.com/ca for details on how to find a Provider, get answers to questions and access valuable health and wellness tips. Thank You again for enrolling in the Plan!



J. Brian Ternan
President
Anthem Blue Cross

How to Obtain Language Assistance

Anthem Blue Cross (Anthem) is committed to communicating with Our Members about their health Plan, no matter what their language is. Interpretation services are available through all of Our Member Services call centers. Simply call the Member Services 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 asked for by contacting Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

You may provide Your preferred written and spoken language directly to Anthem and directly to Your Provider. If You provide Your language preferences to Anthem, this information will be maintained by Anthem and will be shared with Your Provider when the Provider calls to check eligibility or upon request. If Your preferred written language is one of Your health plan's threshold languages, You may receive some Plan information in Your preferred written language. You may update Your preferred written and spoken languages to Your health plan by calling 1-855-634-3381.

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 Member Services number.)

Oral interpretation services are available in fifteen (15) languages.

Auxiliary aids and services are also available for Members with disabilities as well as information in alternate formats. These aids and services are free of charge and will be provided in a timely manner when they are necessary to ensure an equal opportunity for Members with disabilities to participate.

Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write Anthem.

The telephone number for Member Services is 1-855-634-3381. The address is:
P. O. Box 9051
Oxnard, CA 93031-9051

Visit Us on-line
www.anthem.com/ca

Hours of operation
Monday - Thursday
8:00 a.m. to 6:00 p.m. Pacific Time

Friday
8:00 a.m. to 5:00 p.m. Pacific Time

Conformity with Law

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 confirm to the minimum requirements of such law.

This coverage is An Exclusive Provider Organization (EPO) Plan regulated by the California Department of Managed Health Care pursuant to the Health and Safety Code.

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this Agreement constitutes a contract solely between 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. 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 Subscriber for any of Anthem Blue Cross’s obligations to 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.

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 1-855-634-3381 to ensure that You can obtain the health care services that You need.

Delivery of Documents

We will provide an Identification Card (ID Card) and Evidence of Coverage and Disclosure Form for each Subscriber.

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LANGUAGE ASSISTANCE SERVICES

Get Help in Your Language

Language Assistance Services

Curious to know what all this says? We would be too. Here is the English version:

IMPORTANT: Can You read this letter? If not, We can have somebody help You read it. You may also be able to get this letter written in Your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from Our language assistance program, We make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your ID Card.

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TY/TDD:711T).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打 1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(Y/TDD:711TT)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखिवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਥੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਰਿਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าทีมาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าทีช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อทีหมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It Is Important We Treat You Fairly

Notice of Non-Discrimination Required by Federal Law

That is why We follow federal civil rights laws in Our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age,

or disability. For people with disabilities, We offer free aids and services. For people whose primary language is not English, We offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your ID Card for help (TTY/TDD: 711). If You think We failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with Our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Non-Discrimination Required by California Law

Anthem does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender identity, sexual orientation, age or disability. For people with disabilities, We offer free aids and services, and information in alternate formats, free of charge and in a timely manner, when necessary to ensure an equal opportunity to participate.

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If You have grievance against Anthem, You should first call Anthem at 1-800-365-0609 (TDD: 1-866-333-4823) and use Anthem's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help filing a grievance, call Anthem Member Services at 1-800-365-0609.

If You need help with a grievance involving an Emergency, a grievance not satisfactorily resolved by Anthem, or a grievance unresolved for more than thirty (30) days, call the DMHC for assistance. The DMHC also has a toll-free number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC's internet website www.dmhc.ca.gov has complaint forms online.

SCHEDULE OF COST SHARE AND BENEFITS

Anthem Minimum Coverage EPO
49ZK
An Exclusive Provider Organization (EPO) Plan

This Schedule of Cost Share and Benefits sets forth the applicable Cost Shares for benefits available under this Agreement. The term Cost Shares means the applicable Deductibles, Coinsurance, and Out of Pocket Maximums that You must pay for Covered Services You receive under this Agreement. This Schedule 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," "What is Not Covered (Exclusions)," "How Your Claims are Paid" and "Requesting 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.

Services will only be Covered Services if rendered by In Network Providers unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- The services are approved in advance by Anthem. **Please be sure to contact Us if You are not sure if We have pre-approved a service as an Authorized Service.**

Services from an Out of Network Provider are not covered, and You may be responsible for the total amount billed by an Out of Network Provider, except for an Emergency, Urgent Care received at an Urgent Care Center, or for a service pre-approved as an Authorized Service, or, in certain circumstances, when You receive Covered Services at an In Network Facility from an Out of Network Provider. Please read "How Your Claims are Paid" for more details.

Benefits for Emergency and 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" 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.**

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

Transition assistance is a process that allows for continuity of care for new Members whose prior health plan withdrew their health benefit plan from the market, ceased to provide coverage in the individual market, or whose Providers have been terminated from Our Network. If this applies to You, please see the detailed information in the subsection "Continuity of Care" under the section "How Your Coverage Works." You may call Member Services at 1-855-634-3381 to request transition assistance.

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	$8,150 per Benefit Period	Not Covered
Family Plan	$16,300 per Benefit Period	Not Covered

For each Benefit Period You must first satisfy the applicable In Network Medical and Prescription Drug Deductible. 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. No one (1) individual Member can contribute more than their individual Deductible amount. 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. Your In Network Medical and Prescription Drug Deductible for Covered Services will apply towards Your In Network Out of Pocket Maximum.

See "Deductibles" under "How Your Claims are Paid" for a detailed description of how Your Deductible works.

Out of Pocket Maximums	In Network You Pay	Out of Network You Pay
Individual Plan	$8,150 per Benefit Period	Not Covered
Family Plan	$16,300 per Benefit Period	Not Covered

The Out of Pocket Maximums include all Deductibles and Coinsurance You pay during a Benefit Period for all Essential Health Benefits, medical services, child dental and vision services and Prescription Drug services combined. 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. Deductibles and Coinsurance are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Once the applicable Out of Pocket Maximum is satisfied, You will not have to pay any additional Deductibles or Coinsurance for the rest of the Benefit Period. If the Plan covers only one (1) individual Member, the Member will have no further 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 Coinsurance once they have satisfied the applicable individual Out of Pocket Maximum. No one (1) individual Member can contribute more than their 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 Coinsurance for the Benefit Period. All Deductibles 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 or Coinsurance apply to the Out of Pocket Maximum.

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 "How Your Claims are Paid" for a detailed description of how Your Out of Pocket Maximums work.

Coinsurance

The following lists the Coinsurance 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 doctor's office, an Outpatient Facility or during an Inpatient Hospital stay. For services in the office, look up "Doctor (Physician) Visits." 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 Outpatient department of a Hospital, look up "Outpatient Hospital Care." For services during an Inpatient stay, look up "Inpatient Hospital Care."

IMPORTANT: This is an Exclusive Provider Organization (EPO) Plan. SERVICES MUST BE PERFORMED OR SUPPLIES FURNISHED BY AN IN NETWORK PROVIDER IN ORDER FOR BENEFITS TO BE PAYABLE. There are no benefits provided when using an Out of Network Provider and You may be responsible for the total amount billed by an Out of Network Provider, except for services received by an Out of Network Provider as a result of a Medical Emergency, Urgent Care services received at an Urgent Care Center or an Authorized Referral as defined in "Definitions." Additionally, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider.

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 from a Provider who is not an In Network Provider under this Plan care considered Out of Network services and are not covered and You may be responsible for the total amount billed by an Out of Network Provider, except for an Emergency, Urgent Care services received at an Urgent Care Center or for a service pre-approved as an Authorized Service even if You have been referred by another Anthem In Network Provider. Additionally, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider.

Anthem can help You find an In Network Provider specific to Your Plan if You call Member Services at 1-855-634-3381 or access Our web site at www.anthem.com/ca.

Some services listed below require Precertification prior to receiving the service. See "Requesting Approval for Benefits" for more information.

Medical Services

Benefit	You Pay	
	Coinsurance	
	In Network	Out of Network
Acupuncture • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive Primary Care Physician (PCP), Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance	0% Coinsurance	Not Covered
Ambulance Services (Air, Ground and Water) • Precertification is required for ambulance services except in a Medical Emergency (see "Requesting Approval for Benefits" for details) • Out of Network ambulance services covered only in case of Emergency or if Precertified by Us • If Precertified by Us, Out of Network nonemergency ambulance services are subject to the same Cost Shares as In Network services up to $50,000 per occurrence • Out of Network ambulance Providers may bill You for any charges that exceed the Reasonable and Customary Value		
Ambulance Services	0% Coinsurance	**Emergency:** 0% Coinsurance plus all charges in excess of the Reasonable and Customary Value **Nonemergency:** Not Covered
Autism Services • Precertification is required for autism services (see "Requesting Approval for Benefits" for details)		

Benefit	You Pay Coinsurance	
	In Network	Out of Network
Outpatient Office Visits • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive PCP, Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance	0% Coinsurance	Not Covered
Other Outpatient Items and Services	0% Coinsurance	Not Covered
Inpatient Services	0% Coinsurance	Not Covered
Inpatient Doctor/Surgeon Fee (when billed separately from the Inpatient Services)	0% Coinsurance	Not Covered
Diagnostic Services • Precertification is required for certain diagnostic procedures and tests (see "Requesting 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	0% Coinsurance	Not Covered
Diagnostic Imaging Services and Electronic Diagnostic Tests	0% Coinsurance	Not Covered
Advanced Imaging Services	0% Coinsurance	Not Covered
Doctor (Physician) Visits • Additional services received during an office visit may be subject to additional Coinsurance or Copayments • For preventive care visits, please see "Preventive Care Services" below • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive PCP, Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance		
Primary Care Physician (PCP) Visit	0% Coinsurance	Not Covered

Benefit	You Pay Coinsurance In Network	 Out of Network
Specialty Care Physician (SCP) Visit, including Office, Online, and Telehealth Visit	0% Coinsurance	Not Covered
Other Practitioner Office Visit	0% Coinsurance	Not Covered
Retail Health Clinic Visit, includes all Covered Services received at a Retail Health Clinic	0% Coinsurance	Not Covered
PCP Online Visit	0% Coinsurance	Not Covered
PCP Telehealth Visit	0% Coinsurance	Not Covered
Emergency Care Services (Emergency Room) • Additional services received in an Emergency Room may be subject to additional Coinsurance or Copayments • Out of Network covered in case of Emergency only		
Emergency Room Facility Fee	0% Coinsurance per Emergency Room Visit Coinsurance is waived if admitted into the Hospital from the Emergency room	0% Coinsurance per Emergency Room Visit Coinsurance is waived if admitted into the Hospital from the Emergency room
Emergency Room Doctor Fee	Deductible does not apply: No Charge	Deductible does not apply: No Charge
Home Care Services • Precertification is required for home care services (see “Requesting Approval for Benefits” for details) • In Network home care services are limited to one-hundred (100) visits per calendar Year		
Home Care Services	0% Coinsurance per Home Health Care Visit	Not Covered
Hospice Care • Precertification is required for hospice care (see “Requesting Approval for Benefits” for details)	0% Coinsurance	Not Covered
Hospital Services		

Benefit	You Pay Coinsurance In Network	 Out of Network
Inpatient Facility • Precertification is required for Inpatient services (see "Requesting 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 doctor must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time (see "Requesting Approval for Benefits" for details) • Out of Network inpatient services are covered in case of Medical Emergency only. If You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider		
Inpatient Facility Fee	0% Coinsurance	**Emergency:** 0% Coinsurance **Nonemergency:** Not Covered
Residential Treatment Center Facility Fee	0% Coinsurance	Not Covered
Doctor/Surgeon Fee	0% Coinsurance	**Emergency:** 0% Coinsurance **Nonemergency:** Not Covered
Outpatient Facility • Precertification is required for surgical procedures (see "Requesting 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	0% Coinsurance	Not Covered
Ambulatory Surgical Center	0% Coinsurance	Not Covered
Outpatient Visit	0% Coinsurance	Not Covered
Doctor/Surgeon Fee	0% Coinsurance	Not Covered
Maternity Services		
Preconception, Prenatal Care and First Postpartum Check-Up	Deductible does not apply: No Charge	Not Covered

Benefit	You Pay Coinsurance	
	In Network	Out of Network
Postnatal Care • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive PCP, Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance	0% Coinsurance	Not Covered
Medical Supplies, Durable Medical Equipment and Appliances • Precertification is required for certain prosthesis and assistive devices (see "Requesting Approval for Benefits" for details)	0% Coinsurance	Not Covered
Mental Health and Substance Abuse (Chemical Dependency) Services • Precertification is required for certain Mental Health and Substance Abuse services except in an Emergency (see "Requesting Approval for Benefits" for details)		
Outpatient Office Visits • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive PCP, Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance	0% Coinsurance	Not Covered
Other Outpatient Items and Services	0% Coinsurance	Not Covered
Inpatient Services	0% Coinsurance	Not Covered
Inpatient Doctor/Surgeon Fee (when billed separately from the Inpatient Services)	0% Coinsurance	Not Covered

Benefit	You Pay Coinsurance In Network	 Out of Network
Other Eligible Providers If You obtain services from Other Eligible Providers, Your responsibility will be 0% Coinsurance **plus** all charges in excess of the Reasonable and Customary Value		
Outpatient Habilitative Services • Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services	0% Coinsurance	Not Covered
Outpatient Rehabilitative Services • Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services	0% Coinsurance	Not Covered
Preventive Care Services	Deductible does not apply: No Charge	Not Covered
Skilled Nursing Facility • Precertification is required for a Skilled Nursing Facility (see "Requesting Approval for Benefits" for details) • Skilled Nursing Facility is limited to one-hundred (100) days per Benefit Period. A Benefit Period begins on the date You are admitted to a Hospital or Skilled Nursing Facility at a skilled level of care. A Benefit Period ends on the date You have not been an Inpatient in a Hospital or Skilled Nursing Facility, receiving a skilled level of care, for sixty (60) consecutive days. A new Benefit Period can begin only after any existing Benefit Period ends. A prior three (3) day stay in an acute care Hospital is not required. This limit does not apply to Mental Health and Substance Abuse services or autism services		
Skilled Nursing Facility	0% Coinsurance	Not Covered
Urgent Care Center • Additional services received in an Urgent Care Center may be subject to additional Coinsurance or Copayments • For each Member, the In Network Deductible is waived for the first 3 visits combined for the following benefits: non-preventive PCP, Other Practitioner, Retail Health Clinic, online care, telehealth, autism, Mental Health and Substance Abuse, or acupuncture office visits; maternity postnatal care; or Urgent Care visits • For the first 3 visits for these types of benefits combined, the In Network Deductible does not apply to the In Network Coinsurance • After the first 3 visits for these types of benefits combined, the In Network Deductible applies to the In Network Coinsurance		
Urgent Care Services	0% Coinsurance per Urgent Care Center visit	0% Coinsurance per Urgent Care Center visit

Prescription Drugs

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

Anthem uses a Prescription Drug List (formulary) that includes a select number of medications in therapeutic categories and classes. Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

Each Prescription Drug will be subject to a Coinsurance as described below.

If Your Prescription Drug order includes more than one (1) Prescription Drug, a separate Coinsurance will apply to each Prescription Drug.

If the retail or home delivery price for a covered Prescription and/or refill is less than the applicable Coinsurance amount, You will not be required to pay more than that price. The retail or home delivery price paid will constitute the applicable Cost Sharing and will apply toward the Deductible and Out of Pocket Maximum in the same manner as a Coinsurance.

Note: Oral chemotherapy drugs are subject to a maximum Coinsurance not to exceed $200 for a thirty (30) day supply.

Day Supply Limitations. Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower than thirty (30) day supply limit due to other Plan requirements such as prior authorization, quantity limits and/or age limits and utilization guidelines including clinical criteria and recommendations of State and federal agencies. If the quantity of the drug dispensed is reduced due to clinical criteria and/or recommendations of governmental agencies, the Prescription is considered complete.

IMPORTANT NOTE:
Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most Anthem will allow for a Covered Service. Please read “What is Covered” and “How Your Claims are Paid” for more details.

See “What is Covered” and “What is Not Covered (Exclusions)” for descriptions of Covered Services, limitations and exclusions. In cases where Your doctor prescribes a medication that is not on the Anthem Prescription Drug List (formulary), it may be necessary to obtain Prior Authorization in order for the Prescription to be a covered benefit. Doctors 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.

Prescription Drug Deductible • retail and home delivery combined	**In Network You Pay**	**Out of Network You Pay**
Individual Plan	In Network Prescription Drugs are subject to the same In Network Deductible as Your Medical Benefits	Not Covered
Family Plan	In Network Prescription Drugs are subject to the same In Network Deductible as Your Medical Benefits	Not Covered

Benefit	**You Pay** **Coinsurance**	
	In Network	**Out of Network**
Retail Prescription • Retail Pharmacy is limited to up to a thirty (30) day supply per Prescription • Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy • For FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies		
Tier 1	0% Coinsurance	Not Covered
Tier 2	0% Coinsurance	Not Covered
Tier 3	0% Coinsurance	Not Covered
Tier 4	0% Coinsurance	Not Covered

Benefit	You Pay	
	Coinsurance	
	In Network	Out of Network
Home Delivery Prescription • Home Delivery is limited to up to a ninety (90) day supply per Prescription • Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy and are limited to a thirty (30) day supply • For FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies		
Tier 1	0% Coinsurance	Not Covered
Tier 2	0% Coinsurance	Not Covered
Tier 3	0% Coinsurance	Not Covered
Tier 4	0% Coinsurance	Not Covered

Child Dental Services

The following child Dental Services are covered for Members until the end of the month in which they turn nineteen (19).

Covered Dental Services, unless otherwise stated below, are subject to the same calendar Year Deductible and Out of Pocket Maximum as medical and amounts can be found on the second page of this Schedule of Cost Share and Benefits.

Please see “Child Dental Care” in the “What is Covered” section for more information on child Dental Services.

Benefit	You Pay Coinsurance	
	In Network	Out of Network
Diagnostic and Preventive Services	Deductible does not apply: No Charge	Not Covered
Basic Dental Services	0% Coinsurance	Not Covered
Major Dental Services (Endodontic, Periodontal, Oral Surgery, Major Restorative and Prosthodontic)	0% Coinsurance	Not Covered
Medically Necessary Orthodontic Care Services	0% Coinsurance	Not Covered

Child Vision Services

The following vision care services are covered for Members until the end of the month in which they turn nineteen (19). To get the In Network benefit, You must use a Blue View Vision Provider. Visit Our web site or call Us at the number on Your Identification Card if You need help finding a Blue View Vision Provider.

Please see "Child Vision Care" in the "What is Covered" section for a more information on pediatric vision services.

Benefit	You Pay Coinsurance	
	In Network	Out of Network
Routine Eye Exam • Routine eye exam includes refraction • Covered once per calendar Year per Member	Deductible does not apply: No Charge	Not Covered
Standard Plastic or Glass Lenses • One (1) set of lenses per calendar Year per Member • Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received from In Network Providers		
Single Vision	0% Coinsurance	Not Covered
Bifocal	0% Coinsurance	Not Covered
Trifocal	0% Coinsurance	Not Covered
Progressive	0% Coinsurance	Not Covered
Lenticular	0% Coinsurance	Not Covered
Frames (formulary) • One (1) frame covered per calendar Year per Member	0% Coinsurance	Not Covered
Contact Lenses (formulary) • A one (1) Year supply of elective or non-elective contact lenses is covered every calendar Year (applicable to certain contact lenses within the vision formulary) • Non-elective contacts for aniridia and aphakia. Contact lenses for aniridia will be covered up to two (2) contact lenses per eye per calendar Year. Contact lenses for aphakia will be covered up to six (6) contact lenses per eye per calendar Year. Contact lens coverage for these conditions also includes fitting and dispensing		
Elective (conventional and disposable) • These are contact lenses chosen for comfort or appearance	0% Coinsurance	Not Covered

Benefit	You Pay Coinsurance	
	In Network	Out of Network
Non-elective • These are contact lenses that are prescribed to You for a medical condition	0% Coinsurance	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next calendar Year.		
Low Vision • Low vision benefits are only available when received from Blue View Vision Providers		
Comprehensive Low Vision Exam • Covered once every five (5) calendar Years per Member	Deductible does not apply: No Charge	Not Covered
Optical/Non-Optical Aids and Supplemental Testing • Limited to one (1) occurrence of either optical/non-optical aids or supplemental testing per calendar Year per Member	0% Coinsurance	Not Covered

HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about In Network Providers who have entered into an agreement with Anthem and Out of Network Providers who have not. You will also find information about how to access a list of In Network Providers in Your Service Area and the importance of choosing a Primary Care Physician (PCP).

This is an Exclusive Provider Organization (EPO) Plan

To get benefits for Covered Services, You must use In Network Providers, unless We have approved an Authorized Service or if Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

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 or the Exchange to enroll in a different individual health benefit plan.

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

Choice of Doctors and Providers

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 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).

In Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another In Network Provider, benefits will be paid at the In Network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another In Network Provider. All medical care must be under the direction of doctors, unless Medically Necessary or otherwise appropriate.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the “If You Have a Complaint or an Appeal” section of this Agreement.

In Network Providers include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians and gynecologists, geriatricians or other In Network Providers as allowed by Us or as required by law. The PCP is the doctor who may provide, coordinate, and arrange Your health care services. SCPs are In Network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by In Network Providers:

- You will not be required to file any claims for services You obtain directly from In Network Providers. In Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your In Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Agreement.
- When required, prior approval of benefits is the responsibility of the In Network Provider. See the “Requesting Approval for Benefits” section.

If there is no In Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out of Network Provider for that service as an Authorized Service.

Out of Network Services

Services which are not obtained from a PCP, SCP or another In Network Provider, or that are not an Authorized Service will be considered an Out of Network service and are not covered. The only exceptions are Emergency Care, Urgent Care received from an Urgent Care Center, and ambulance services related to an Emergency for transportation to a Hospital. **In these cases, Out of Network Providers are paid at the Reasonable and Customary Value.**

Also, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

How to Find a Provider in the Network

There are three (3) 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.

1. See Your Plan's directory of In Network Providers at www.anthem.com/ca, which lists the doctors, Providers, and Facilities that participate in this Plan's Network.
2. Call Member Services to ask for a list of doctors and Providers that participate in this Plan's Network based on specialty and geographic area.
3. Check with Your doctor or Provider.

If You need details about a Provider's license or training or help choosing a doctor who is right for You, call the Member Services number on the back of Your Member 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.

Primary Care Physician (PCP)

The PCP is a doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine doctors, family practice doctors, general practitioners, pediatricians, or obstetricians/gynecologists (OB/GYNs). As Your first point of contact, the PCP gives a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

Selecting a Primary Care Physician (PCP)

As a Member, You and Your enrolled family member(s) will be assigned a PCP upon enrollment. This PCP will be selected based on Your geographic location and be consistent with Your age, gender, and language. We will notify the Subscriber by letter with the assignment of the PCP for them and their family member(s) enrolled in this Plan. If We assign You a PCP, You may use that PCP or You may choose another PCP. While You are required to select a PCP, You are not required to visit the selected PCP and do not require a Referral for Specialist visits. Please see "How to Find a Provider in the Network" for more details and remember, You do not have an Out of Network benefit, so You must choose an In Network PCP.

Your Network of Providers

Please note that We have several networks, and an In Network Provider for one plan may not be an In Network Provider for another plan. Be sure to check Your Identification Card or call Member Services to find out which network this Plan uses.

Information about Your Network can be found in "Subscriber and Premium Information," by calling Member Services at 1-855-634-3381 or on Our web site www.anthem.com/ca.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You choose a PCP, make an appointment with Your PCP. During this appointment, get to know Your PCP and help Your PCP get to know You. At Your first appointment, talk to Your PCP about:

- personal health history
- family health history
- lifestyle
- any health concerns You have

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. To see a doctor, call their office:

- Tell them You are an Anthem Member.
- Have Your Member Identification Card handy. The doctor's office may ask You for Your Member ID number.
- Tell them the reason for Your visit.

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

Dental Providers

You must select an In Network dentist to receive dental benefits. Please call Member Services at 1-800-627-0004 for help in finding an In Network dentist or visit Our web site at www.anthem.com/ca. Please refer to Your ID Card for the name of the dental program that In Network Providers have agreed to service when You are choosing an In Network dentist.

Continuity of Care

Transition Assistance for New Members

Transition assistance is a process that allows for continuity of care for new Members whose prior health plan withdrew their health benefit plan from the market or ceased to provide coverage in the individual market. If this applies to You, You may request transition assistance if any one (1) of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Member and the Out of Network Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with Us.
3. A pregnancy. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of the terminal illness.
5. Completion of Covered Services shall not exceed twelve (12) months from the time the Member enrolls with Us.
6. Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred an eighty (180) days of the time the Member enrolls with Anthem.

Please contact Member Services at 1-855-634-3381 to request transition assistance or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Transition assistance does not provide coverage for services not otherwise covered under the Agreement.

We will notify You whether or not Your request for transition assistance is approved. We will also notify the Provider if the request is approved. Financial arrangements with Out of Network Providers are negotiated on a case-by-case basis. We will request that the Out of Network Provider agree to negotiate reimbursement and/or contractual requirements that apply to In Network Providers, including payment terms. If the Out of Network Provider does not agree to negotiate said reimbursement and/or contractual requirements, We are not required to continue that Provider's services.

If You disagree with Our determination regarding continuation of care, please refer to the section "If You Have a Complaint or an Appeal."

Continuity of Care after Termination of 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:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the 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.
3. A pregnancy. A pregnancy is the three (3) trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
6. Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within 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 Member Services at 1-855-634-3381. 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 "If You Have a Complaint or an Appeal."

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Agreement has the right to services or benefits under this Agreement. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Agreement, he/she is responsible for the actual cost of the services or benefits.

After Hours Care

If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor'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 Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call 911.
- Your coverage includes benefits for services rendered by Providers other than In Network Providers when the condition treated is an Emergency, as defined in this Agreement.

Authorized Referral

In some circumstances, We may authorize 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 Out of Network Provider. In such circumstance, You or Your doctor 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 1-855-634-3381 for Authorized Referral information or to request authorization.

In Network Providers include PCPs, 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.

Relationship of Parties (Anthem and In Network Providers)

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.

TIMELY ACCESS TO CARE

Timely Access to Medical Care

Anthem has contracted with health care service Providers to provide Covered Services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its contracted Provider networks have the capacity and availability to offer appointments within the following timeframes:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment
- **Non-Urgent appointments for primary care:** within ten (10) business days of the request for an appointment
- **Non-Urgent appointments with Specialists:** within fifteen (15) business days of the request for an appointment
- **Appointments for ancillary services (diagnosis or treatment of an injury, illness or other health condition) that are not Urgent Care:** within fifteen (15) business days of the request for an appointment

For Mental Health and Substance Abuse care:

- **Urgent Care appointments for services that do not require prior authorization:** within forty-eight (48) hours of the request for an appointment
- **Urgent Care appointments for services that require prior authorization:** within ninety-six (96) hours of the request for an appointment
- **Non-Urgent appointments with Mental Health And Substance Abuse Providers who are not psychiatrists:** within ten (10) business days of the request for an appointment
- **Non-Urgent appointments with Mental Health And Substance Abuse Providers who are psychiatrists:** within fifteen (15) business days of the request for an appointment. Due to accreditation standards, the date will be ten (10) business days for the initial appointment only

If a health care Provider determines that the waiting time for an appointment can be extended without a detrimental impact on Your health, the Provider may schedule an appointment for a later time than noted above.

Anthem arranges for telephone triage or screening services for You twenty-four (24) hours per day, seven (7) days per week with a waiting time of no more than thirty (30) minutes.

Providers will utilize a telephone answering machine and/or an answering service and/or office staff, during and after business hours, to inform You of the wait time for a return call from the Provider and how the Member may obtain Urgent or Emergency Care or how to contact another Provider who is on-call for telephone triage or screening services.

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of an In Network appointment.

Timely Access to Dental Care

Anthem has contracted with In Network dentists to provide Covered Services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its network of In Network dentists have the capacity and availability to offer appointments within the following timeframes:

- **Urgent care appointments:** within seventy-two (72) hours of the request for an appointment
- **Non-urgent appointments for primary care:** within thirty-six (36) business days of the request for an appointment
- **Preventive dental care appointments:** within forty (40) business days of the request for an appointment

If an In Network dentist determines that the waiting time for an appointment can be extended without a detrimental impact on Your health, the In Network dentist may schedule an appointment for a later time than noted above.

In Network dentists are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how You can obtain Urgent or Emergency Care including, when applicable, how to contact another dentist who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care.

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

Timely Access to Vision Care

Anthem has contracted with In Network vision Providers to provide Covered Services in a manner appropriate for Your condition, consistent with good professional practice. Anthem ensures that its network of In Network vision Providers have the capacity and availability to offer appointments within the following timeframes:

- **Urgent care appointments:** within seventy-two (72) hours of the request for an appointment
- **Non-urgent appointments for primary care:** within thirty-six (36) business days of the request for an appointment
- **Preventive vision care appointments:** within forty (40) business days of the request for an appointment

If an In Network vision Provider determines that the waiting time for an appointment can be extended without a detrimental impact on Your health, the In Network Provider may schedule an appointment for a later time than noted above.

In Network vision Providers are required to have an answering service or a telephone answering machine during non-business hours, which will provide instructions on how You can obtain Urgent or Emergency Care including, when applicable, how to contact another Provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver Urgent or Emergency Care.

If You need the services of an interpreter, the services will be coordinated with scheduled appointments and will not result in a delay of Your appointment.

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 doctor 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.

REQUESTING APPROVAL FOR BENEFITS

Your Agreement includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Agreement. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that is being requested. When this happens the service can be requested again in another setting or place of care and will be reviewed again for Medical Necessity. At times a different type of Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- a service may be denied on an Inpatient basis at a Hospital, but may be approved if provided on an Outpatient basis in a Hospital setting.
- a service may be denied on an Outpatient basis in a Hospital setting, but may be approved at a free-standing imaging center, infusion center, Ambulatory Surgical Center, or in a doctor's office.
- a service may be denied at a Skilled Nursing Facility, but may be approved in a home setting.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. "Clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

If You have any questions about the Utilization Review process, the medical policies, or clinical guidelines, You may call the Member Service phone number on the back of Your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. the service or supply must be a Covered Service under Your Plan;
4. the service cannot be subject to an exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Preservice Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

  Precertification – A required preservice review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental or Investigational as those terms are defined in this Agreement. The review may include the place or setting of the service. For further information, please see "Reviewing Where Services are Provided" above.

  For admissions following Emergency Care, You, Your authorized representative or doctor 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 required for the first forty-

eight (48) hours for a vaginal delivery or ninety-six (96) hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Preservice and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification. Post-service 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 doctor 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)
    - transcranial magnetic stimulation (TMS)
    - residential treatment (including detoxification and rehabilitation)
    - partial Hospitalization
    - Intensive Outpatient Programs
    - behavioral health treatment for pervasive developmental disorder or autism
- Skilled Nursing Facility stays
- transcranial magnetic stimulation (TMS)
- bariatric surgery and organ and tissue transplants
- 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: doctor's office, infusion center, Outpatient Hospital or clinic, or Your home or other residential setting
- home care services
- Inpatient hospice care
- surgical procedures, wherever performed
- cryopreservation
- temporomandibular services
- diagnostic procedures, tests and advanced imaging procedures, wherever performed
- The following reconstructive services:
    - dermabrasion of the face or other site
    - rosacea treatment

  - scar revision
  - tattooing
  - collagen injections
  - electrolysis
  - hair transplants (hairplasty)
  - botox injections
  - chemical peels
- genetic testing
- implants, prosthetics, assistive devices and durable medical equipment
- ambulance in a nonemergency
- hyperbaric oxygen treatment
- new and emerging technology
- unlisted/unspecified codes
- physical therapy
- occupational therapy
- speech therapy

For a list of current procedures, or the site of surgical procedures, requiring Precertification, please call Member Services at 1-855-634-3381.

Who is Responsible for Precertification

Typically, In Network Providers know which services need Precertification and will get any Precertification when needed. Your PCP 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 doctor ("requesting Provider") will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or 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. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
In Network	Provider	The Provider must get Precertification when required.

Provider Network Status	Responsible Party	Comments
Out of Network	Member	Member has no benefit coverage for an Out of Network Provider unless: • the Member gets approval to use an Out of Network Provider before the service is given, or • the Member requires an Emergency Care admission (see note below). Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary. However, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.
BlueCard® Provider	Member **(Except for Inpatient admissions)**	• Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If You are not satisfied with Our decision under this section of Your benefits, please refer to the “If You Have a Complaint or an Appeal” section to see what rights may be available to You.

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 the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent preservice review	Seventy-two (72) hours from the receipt of the request
Non-urgent preservice review	Five (5) business days from the receipt of the request
Concurrent/continued stay review when hospitalized at the time of the request and no previous authorization exists	Twenty-four (24) hours from the receipt of the request, We may request additional information within the first twenty-four (24) hours and then extend to seventy-two (72) hours
Urgent concurrent/continued stay review 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
Urgent concurrent/continued stay review when request is received less than twenty-four (24) hours before the end of the previous authorization	Seventy-two (72) hours from the receipt of the request
Non-urgent concurrent/continued stay review	Five (5) business days from the receipt of the request
Post-service review	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 of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one (1) or more of the following methods: verbal, written and/or electronic.

Important Information

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) and/or offer an alternative benefit if, in Our discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

We may also 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 We exempt a process, Provider or claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or modify any such exemption with advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line Precertification list or contacting the Member Services number on the back of Your Identification Card.

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 (1) or more clinical Utilization Review 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.

Health Plan Individual Case Management

Our health plan case management programs (case management) help 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 doctor(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 Plan. We will make Our decisions case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem A decision to provide extended benefits or approve alternate care in one (1) 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

This section describes the Covered Services available under this 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 following sections of this contract for more information about the Covered Services described in this section:

- "Schedule of Cost Share and Benefits" – for amounts You need to pay and benefit limits
- "Requesting Approval for Benefits" – for details on selecting Providers and services that require Precertification

  IMPORTANT: The "Requesting Approval for Benefits" section includes a list of services that require Precertification. For any of the services listed in this section, You should refer to "Requesting Approval for Benefits" to determine if Precertification is required.
- "What is Not Covered (Exclusions)" – for details on services that are not covered

Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to Your claims. For example, if You have Inpatient surgery, benefits for Your Hospital stay will be described under "Hospital Services," "Inpatient Hospital Care" and benefits for Your doctor's services will be described under "Inpatient Professional Services." 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 doctor's office, an Urgent Care Center, an Outpatient Facility, or an Inpatient Facility. 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.

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary nonemergency 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.
- and one (1) or more of the following are met:
  You are taken:
  1. from Your home, scene of an accident or Medical Emergency to a Hospital;
  2. between Hospitals, including when We require You to move from an Out of Network Hospital to an In Network Hospital or
  3. between a Hospital, Skilled Nursing Facility (ground transport only) or 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 an injury by medical professionals during ambulance service, even if You are not taken to a Facility.

If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a Medical Emergency existed even if You are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by Us prior to the benefits being paid.

In some areas a 911 Emergency response system has been established. This system is to be used only when there is an Emergency Medical Condition that requires an Emergency response.

If You reasonably believe that You are experiencing an Emergency, You should call 911 or go directly to the nearest Hospital Emergency room.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, require Precertification.

Air and Water Ambulance

Air ambulance services are subject to Medical Necessity review by Us. We retain the right to select the air ambulance Provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for nonemergency 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 (1) 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 Services

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 "Requesting 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 under "What is Covered."

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 doctor 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 (1) of the following:
    1. a qualified autism service Provider
    2. a qualified autism service professional supervised and employed by the qualified autism service Provider responsible for the treatment plan
    3. a qualified autism service paraprofessional supervised and employed by the qualified autism service Provider responsible for the treatment plan
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:
    1. describes the patient's behavioral health impairments to be treated
    2. 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
    3. provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
    4. 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 who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification 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 who is nationally certified; or
- a person licensed as a doctor, 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, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service Provider,
- is 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 who meets the education and experience qualifications defined in the State regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, or who meets equivalent criteria in the state in which he or she practices if not providing services in California,
- has training and experience in providing services for pervasive developmental disorder or autism pursuant to applicable State law, and
- is employed by the qualified autism service Provider or an entity or group that employs qualified autism service Providers responsible for the autism treatment plan.

For purposes of this section “qualified autism service paraprofessional” is an unlicensed and uncertified individual who meets all of the following requirements:

- is supervised by a qualified autism service Provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice,
- provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service Provider,
- meets the education and training qualifications set forth in State regulations adopted pursuant to State law concerning the use of paraprofessionals in group practice Provider behavioral intervention services,
- has adequate education, training, and experience, as certified by a qualified autism service Provider or an entity or group that employs qualified autism service Providers, and
- is employed by the qualified autism service Provider or an entity or group that employs qualified autism service Providers responsible for the autism treatment plan.

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.

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 (1) 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 of Health and Human Services 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 (FDA);
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 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.

All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to Our Clinical Coverage Guidelines, related policies and procedures.

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 doctor 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 are 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.

Note: If You decide to receive dental services that are not covered under this Agreement, an In Network Provider who is a dentist may charge You his or her usual and customary rate for those services. Prior to providing You with dental services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about the dental services that are covered under this Agreement, please call Member Services at 1-855-634-3381.

Diabetes Services

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 in the "Medical Supplies, Durable Medical Equipment and Appliances" benefit.

2. diabetes Outpatient self-management education services, which:
    a. are 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. include self-management training, education and nutrition therapy to enable the Member to properly use the equipment, supplies and medications necessary to manage the disease
    c. are supervised by a doctor

    Note: Diabetes education services are covered at no cost to the Member under the "Preventive Care Services" benefit.

3. the following medications and supplies are covered in the "Prescription Drugs" benefit:
    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 Home Delivery Prescription Drug program.

4. screening for gestational diabetes and type 2 diabetes mellitus are covered in the "Preventive Care Services" benefit.

Diagnostic Services Outpatient

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:

- CT scan
- CTA scan
- magnetic resonance imaging (MRI)
- magnetic resonance angiography (MRA)
- magnetic resonance spectroscopy (MRS)
- nuclear cardiology
- PET scans
- PET/CT fusion scans
- QCT bone densitometry
- diagnostic CT colonography

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

Doctor (Physician) Visits

Covered Services include:

Office Visits for medical care (including second opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that doctor visits in the home are different than the "Home Care Services" benefit described later in this section.

Retail Health Clinic Care 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 assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor'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 doctor's office.

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Health Education for 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.

Additional Services in an Office Setting. Additional services received during an office visit include, but are not limited to:

- 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

Osteoporosis for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all FDA-approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Online Visits. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online 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 doctors outside the online care panel, benefit Precertification, or doctor to doctor discussions. For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse (Chemical Dependency) Services" section.

Telehealth Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Agreement. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. 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 the use of facsimile, audio-only telephone, texting or electronic mail. If You have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of Your Identification Card.

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 doctor and managed by a health care professional in consultation with a doctor who specializes in the treatment of metabolic disease and who is In Network or to whom You have received an Authorized Referral. 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 doctor 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 doctor 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 (1) gram of protein per serving.

Emergency Care Services

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. For information on Your Cost Shares for Emergency Services, please see the "Schedule of Cost Share and Benefits," the subsection "Inter-Plan Arrangements" in "How Your Claims are Paid" and the benefit "Ambulance Services" above.

Benefits are available in a Hospital Emergency room 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 manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following: 1) placing the patient's health in serious jeopardy, 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 and such other acute conditions.

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:

- 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.

Emergency Care means a medical or behavioral health exam done in the Emergency department of a Hospital, and includes services routinely available in the Emergency department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Stabilize, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the 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.

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 Reasonable and Customary Value for ambulance services received in and outside of California. If Emergency Care is rendered within California by an Out of Network Provider (with the exception of an ambulance Provider), You will not be responsible for any amount in excess of the Reasonable and Customary Value and You will only pay Your Copayment or Coinsurance and any applicable Deductible.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your doctor calls Us as soon as possible. If You or Your doctor does not call Us, You may have to pay for services that are determined to be 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 not be available unless We agree to cover them as an Authorized Service. However, if You receive Covered Services at an In Network Facility at which,

or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Habilitative Services

Habilitative Services are health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not 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.

Note: Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other 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 doctor 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:

- visits by a licensed health care professional, including nursing services by an R.N. or L.P.N., a therapist or home health aide
- infusion therapy; refer to “Therapy Services Outpatient,” later in this section for more information
- medical/social services
- diagnostic services
- nutritional guidance
- training of the patient and/or family/caregiver
- home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider.
- medical supplies
- durable medical equipment
- therapy services
- private duty nursing in the home

Limitations:

- 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, and
- up to three (3) visits per day.
- The ordering doctor 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 Care Agency or Visiting Nurse Association.
- These limitations and home health care services (as described in this section) do not include behavioral health treatment for pervasive developmental disorder or autism (see “Autism Services” above).

Hospice Care

Hospice care is a coordinated plan of home, Inpatient and/or Outpatient care that provides palliative, supportive medical, psychological, psychosocial and other health services to terminally ill patients.

Covered Services and supplies are those listed below if part of an approved treatment plan and when rendered by a hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness.

- care rendered by an interdisciplinary team with the development and maintenance of an appropriate plan of care
- short-term Inpatient Facility care when required in periods of crisis or as respite care
- skilled nursing services, home health aide services and homemaker services provided 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 hydration and feeding tubes
- physical therapy, occupational therapy, speech therapy and respiratory therapy
- pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies
- bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member's death. Bereavement services are available to surviving covered family members.

In order to receive hospice benefits 1) Your doctor and the hospice medical director must certify that You are terminally ill and have approximately twelve (12) months to live, and 2) Your doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment plan. The hospice must maintain a written treatment plan on file and furnish to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Agreement.

Hospital Services

Inpatient Hospital Care

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.

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- a room with two (2) or more beds
- a private room. The most the Agreement 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.
- routine nursery care for newborns during the mother's normal Hospital stay
- meals, special diets
- general nursing services
- operating, childbirth and treatment rooms and equipment
- prescribed drugs
- anesthesia, anesthesia supplies and services given by the Hospital or other Provider
- medical and surgical dressings and supplies, casts, and splints
- diagnostic services
- therapy services
- acute psychiatric Facilities 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 by California law. Also see the definition of "Residential Treatment Center."

Inpatient Professional Services

Covered Services include:

- medical care visits
- intensive medical care when Your condition requires it
- treatment for a health problem by a doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two (2) or more doctors during one (1) Hospital stay when the nature or severity of Your health problem calls for the skill of separate doctors.
- a personal bedside exam by another doctor when asked for by Your doctor. 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 doctor 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

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital
- freestanding Ambulatory Surgical Center
- Mental Health and Substance Abuse Facility
- 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
- 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
- chemotherapy
- radiation
- dialysis

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

- 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, postnatal, and postpartum 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
- expanded Alpha Feto Protein testing, a Statewide prenatal genetic testing program administered by California's State Department of Health Services, with zero Cost Share
- 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

Note: 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.

Please see "Continuity of Care" in the "How Your Coverage Works" section regarding a request to continue to see the same Provider for services.

Contraceptive Benefits

Benefits include oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for further details.

Abortion Services

Coverage includes benefits for abortions.

Family Planning Services

Please see the benefit "Preventive Care Services" below. 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.
- over-the-counter FDA-approved contraceptive methods as prescribed by a health care Provider
- women's contraceptives and sterilization procedures

Fertility Preservation Services

Benefits include fertility preservation services, when Medically Necessary, to prevent iatrogenic infertility.

Medical Supplies, Durable Medical Equipment and Appliances

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 Provider

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 simply purchasing the equipment.

Benefits include repair and replacement costs, except when damage is due to neglect. Benefits also include 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

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

Benefits are available for Members who are certified as deaf or hearing impaired by either a doctor or licensed audiologist. Covered Services include:

- routine hearing screenings (see the benefit "Preventive Care Services" below)
- hearing exams to determine the need for hearing correction (see the benefit "Preventive Care Services" below)
- services related to the ear or hearing, such as Outpatient care to treat an ear infection and Outpatient Prescription Drugs, supplies and supplements (see the benefits "Doctor (Physician) Visits" above and "Prescription Drugs" below)
- cochlear implants – A surgically implanted device that allows hearing

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 must be ordered by a doctor and include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Agreement also 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 (1) 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 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
- prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy
- colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
- restoration prosthesis (composite facial prosthesis)

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 Band-Aids, thermometers, and petroleum jelly.

Diabetic Equipment and Supplies

Your Agreement includes coverage for diabetic equipment and supplies (insulin pump, blood glucose monitor, lancets and test strips, etc.).

Blood and Blood Products

Your Agreement also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

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

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).

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 "Requesting Approval for Benefits").

(See the "Autism Services" section above for coverage and Precertification requirements for those services.)

Coverage is provided for Severe Mental Illness (SMI) for a person of any age and Serious Emotional Disturbances of a Child (SED), 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 for an intensive Outpatient psychiatric treatment program for Mental Health
- electroconvulsive therapy

Inpatient Services in a Joint Commission on Accreditation of Healthcare Organization-accredited 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 doctors 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, doctor services, drugs, dependency recovery services, education and counseling
- residential treatment which is specialized twenty-four (24) hour treatment in a licensed Joint Commission on Accreditation of Healthcare Organization or Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited 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.
- online visits when available in Your area. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online 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 doctors outside the online care panel, benefit Precertification, or doctor to doctor discussions.

Inpatient Doctor/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 "Autism Services" above.

Preventive Care Services

Preventive care services include screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable State law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use an In Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem, may be covered under the "Diagnostic Services Outpatient" benefit instead of this benefit, if the coverage does not fall within the State or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    - breast cancer
    - cervical cancer
    - high blood pressure
    - type 2 diabetes mellitus
    - cholesterol
    - child or adult obesity
    - colorectal cancer
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:
    - the American Academy of Pediatrics Bright Futures Recommendations for pediatric preventive health care and
    - 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. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - women's contraceptives, sterilization procedures and counseling. This includes the eighteen (18) FDA-approved contraceptive methods:
        - 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 doctor 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 "Schedule of Cost Share and Benefits." Also see "Prescription

Drugs" below. If there is one (1) or more therapeutic equivalent of a contraceptive drug, device or product, Anthem will cover at least one (1), if available at a $0 Cost Sharing.
    - injectable contraceptives and patches
    - contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants
    - over-the-counter FDA-approved contraceptives for women as prescribed
    - family planning counseling and education
    - voluntary sterilization procedures
    - 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
    - for FDA-approved, Self-Administered hormonal contraceptives, up to a twelve (12) month supply is covered when dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies
  - breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) per calendar Year or as required by law
  - gestational diabetes screening
  - well woman visits that are age and developmentally appropriate, including preconception and prenatal care
  - screening and counseling for sexually transmitted infections
  - screening and counseling for human immunodeficiency virus (HIV)
  - screening and counseling for interpersonal and domestic violence, and
  - testing for human papillomavirus (HPV)
5. Preventive care services for tobacco cessation for Members age eighteen (18) and older as recommended by the United States Preventive Services Task Force including:
  - counseling
  - Prescription Drugs obtained at a Retail or Home Delivery Pharmacy
  - nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
  - aspirin
  - folic acid supplement
  - bowel preparations

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on Your Identification Card for more details about these services or view the federal government's web sites:

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

Rehabilitative Services

Rehabilitative Services are health care services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.

Note: Limits for Habilitative and Rehabilitative Services shall not be combined. Anthem does not have limits on Habilitative or Rehabilitative Services.

Skilled Nursing Facility

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.

Covered services include:

- doctor and nursing services
- room and board
- drugs prescribed by a doctor 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

Surgery

Your Agreement covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an Ambulatory Surgical Center. Covered Services include:

- accepted 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

Oral Surgery

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, or ectodermal dysplasia; or other craniofacial anomalies associated with cleft palate
- orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part
- oral/surgical correction of accidental injuries
- treatment of non-dental lesions, such as removal of tumors and biopsies
- incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities 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.

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

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.

Bariatric Surgery

Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity. You or Your doctor must obtain Precertification for all bariatric surgical procedures.

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 surgery Facility. All travel expenses must be approved by Anthem in advance.

- transportation for the Member to and from the surgery Facility 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 surgery Facility up to $130 per trip for a maximum of two (2) trips (the initial surgery and one (1) follow-up visit)
- one (1) hotel room, double occupancy 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

Member Services will confirm if the bariatric travel benefit is provided in connection with access to the selected bariatric surgery Facility. Details regarding reimbursement can be obtained by calling the Member Services toll free at 1-855-634-3381. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services Outpatient

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 benefits "Habilitative Services" and "Rehabilitative Services" 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 doctor. Covered Services include:

- **Physical Therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **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 a 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.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including 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 or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** – Doctor 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. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
    - 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 (TPN)
    - 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
- **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, administration and treatment planning.
- **Respiratory/Inhalation 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.

Transgender Services

Benefits are provided for services and supplies in connection with gender transition when a doctor 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.

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 (1) 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 Member Services at 1-855-634-3381 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: Human Organ and Bone Marrow/Stem Cell/Cord Blood

This section describes benefits for certain covered transplant procedures that You get during the transplant benefit period. Any Covered Services related to a covered transplant procedure, received before or after the transplant benefit period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Agreement.

Covered Transplant Procedure

A covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood transplants and infusions as determined by Anthem, including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Agreement includes one (1) human leukocyte antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits, not to exceed $30,000 per transplant, for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the ten (10) best matched donors, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to ninety (90) days from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant benefit period starts one (1) day prior to a covered transplant procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In Network transplant Provider agreement. Contact the case manager for specific In Network transplant Provider information for services received at or coordinated by an In Network transplant Provider Facility. Services received from an Out of Network transplant Facility starts one (1) day prior to a covered transplant procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, You will need to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In Network transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are In Network transplant Providers. Contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the covered transplant procedure, You or Your Provider must call Our transplant department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before We will cover benefits for a transplant. Your doctor must certify, and We must agree, that the transplant is Medically Necessary. Your doctor should send a written request for Precertification to Us as soon as possible to start this process. Please see the “Requesting Approval for Benefits” section for how to obtain Precertification.

Please note that there are instances where Your Provider requests approval for human leukocyte antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

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

Transportation and Lodging

We will provide travel expenses incurred by the Member, up to a maximum $10,000 per transplant, as determined by Us, when You obtain prior approval and are required to travel more than seventy-five (75) miles from Your residence to reach the Facility where Your transplant evaluation and/or transplant work-up and covered transplant procedure will be performed. Our assistance with travel expenses includes transportation to and from the Facility and lodging for the patient and one (1) companion. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two (2) companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

The human organ and bone marrow/stem cell/cord blood transplant services benefits or requirements described above do not apply to the following:

- cornea, ventricular assist devices; and
- any Covered Services, related to a covered transplant procedure, received prior to or after the transplant benefit period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow/stem cells is included in the covered transplant procedure benefit regardless of the date of service.

The above services are covered as Inpatient services, Outpatient services or doctor home visits and office services depending where the service is performed and are subject to Member Cost Shares.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency room. Urgent health problems include earache, sore throat and fever (not above one-hundred and four (104) degrees). Benefits for Urgent Care may include:

- X-ray services
- care for broken bones
- tests such as flu, urinalysis, pregnancy test, rapid strep
- lab services
- stitches for simple cuts, and
- draining an abscess

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 doctor or In Network optometrist and up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any calendar Year 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 (1) 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).

Benefits include medical and surgical treatment of injuries and illnesses of the eye, including contact lenses to treat aphakia and aniridia. Vision screenings required by federal law are covered under the “Preventive Care Services” benefit.

Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility and are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to You in a medical setting. Benefits for drugs that You inject or get through Your Pharmacy benefit (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered as written. As part of these features, Your prescribing doctor may be asked to give more details before We can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

The criteria which are called drug edits, may include requirements based on one (1) or more of the following:

- specific clinical criteria and/or recommendations made by State or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration)
- specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies)) as recommended by the FDA
- step therapy requiring one (1) drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated
- use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of FDA-approved drugs that have been reviewed and recommended for use based on their quality and cost effectiveness)

If You or Your prescribing doctor disagree with Our decision, You may file an exception request. Please see the section "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List."

Precertification

Precertification may be required for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of Our decision to both You and Your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Requesting Approval for Benefits" for more details.

If Precertification is denied, You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Agreement.

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one (1) or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. An In Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In Network Provider must have signed a Designated Pharmacy Provider agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A patient care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

We may also require You to use a Designated Pharmacy Provider to obtain Specialty Drugs for treatment of certain clinical conditions such as hemophilia. We reserve Our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a drug, if in Our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, You will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our web site at www.anthem.com/ca.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

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

Note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or Outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if Your drugs should be covered. Your In Network pharmacist will be told if prior authorization is required and if any additional details are needed for Us to decide benefits.

Prior Authorization

Prior authorization is the process of getting benefits approved before certain Prescriptions can be filled.

Prescribing Providers must obtain prior authorization for drug edits in order for You to get benefits for certain drugs. At times, Your Provider will initiate a prior authorization on Your behalf before Your Pharmacy fills Your Prescription. At other times, the Pharmacy may make You or Your Provider aware

that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

The criteria, which are called drug edits, may include requirements based on one (1) or more of the following:

- specific clinical criteria and/or recommendations made by State or federal agencies (including, but not limited, to requirements regarding age, test result requirements, presence of a specific condition or disease, dose and/or frequency of administration)
- specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies)) as recommended by the FDA
- step therapy requiring one (1) drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated
- use of a Prescription Drug List (as described below)

If You or Your prescribing doctor disagree with Our decision, You may file an exception request. Please see the section "Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List."

You or Your Provider can get the list of the drugs that require prior authorization by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our web site at www.anthem.com/ca. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Requests for prior authorization must be submitted by Your Provider using the required uniform prior authorization form. If You are requesting an exception to the step therapy process, Your Provider must use the same form. Upon receiving the completed form, for either prior authorization or step therapy exceptions, We will review the request and give Our decision to both You and Your Provider within seventy-two (72) hours for non-urgent requests, or twenty-four (24) hours if exigent circumstances exist. 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 Agreement.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or alternate benefits, if in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied, You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Agreement.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the 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. Controlled Substances must be prescribed by a licensed Provider with an active Drug Enforcement Administration (DEA) license.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's 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
- Self-Administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a twelve (12) month supply of FDA-approved, Self-Administered hormonal contraceptives, when

dispensed or furnished at one (1) time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for more details.

- flu shots (including administration)

Where You Can Get Prescription Drugs

In Network Pharmacy

You can visit one (1) of the local Retail Pharmacies in Our network. Give the Pharmacy the Prescription from Your doctor and Your Identification Card and they will file Your claim for You. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when You get the drug. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of In Network Pharmacies may be limited. If this happens, We may require You to select a single In Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single In Network Pharmacy. We will contact You if We determine that use of a single In Network Pharmacy is needed and give You options as to which In Network Pharmacy You may use. If You do not select one of the In Network Pharmacies We offer within thirty-one (31) days, We will select a single In Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You have a Complaint or an Appeal" section of this Agreement.

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single In Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single In Network Provider. We will contact You if We determine that use of a single In Network Provider is needed and give You options as to which In Network Provider You may use. If You do not select one (1) of the In Network Providers We offer within thirty-one (31) days, We will select a single In Network Provider for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You Have a Complaint or an Appeal" section of this Agreement.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered 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. We may require You or Your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When You use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your doctor to get prior authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your Prescription.

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our web site at www.anthem.com/ca.

When You Order Your Prescription Through the PBM's Specialty Pharmacy

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Pharmacy. Specialty Drugs are limited to a thirty (30) day supply per fill. The PBM's Specialty Pharmacy 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.

How to Obtain an Exception to the PBM's Specialty Pharmacy Program

If You believe that You should not be required to get Your Specialty Drug through the PBM's Specialty Pharmacy program, You or Your doctor must complete a Specialty Pharmacy program exception 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 Pharmacy Member Services on the phone number on the back of Your Identification Card 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 PBM's 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.

Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the PBM's 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 PBM's Specialty Pharmacy and it does not arrive, if Your doctor 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 a participating Pharmacy near You. A Member Services representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written Prescriptions from Your doctor or have Your doctor send the Prescription to the Home Delivery Pharmacy. Your doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible or Coinsurance amounts that apply when You ask for a Prescription or refill.

Maintenance Medication

A 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 the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number on the back of Your Identification Card or check Our web site at www.anthem.com/ca for more details.

If You are taking a Maintenance Medication, You may get the first thirty (30) day supply and one (1) thirty (30)-day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy 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. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each Year through the Home Delivery Pharmacy. You can tell Us Your choice by phone at 1-833-236-6196 or by visiting Our web site at www.anthem.com/ca.

When using Home Delivery, We suggest that You order Your refill two (2) weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery program, You can call Pharmacy Member Services toll-free at 1-833-236-6196.

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

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 Prescription Drug List, drugs and medications to treat infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered injectables except insulin. Please check with the Home Delivery Prescription Drug program Member Services department at 1-833-236-6196 for availability of the drug or medication.

What You Pay for Prescription Drugs

If the retail or home delivery price for a covered Prescription and/or refill is less than the applicable Copayment or Coinsurance amount, You will not be required to pay more than that price. The retail or home delivery price paid will constitute the applicable Cost Sharing and will apply toward the Deductible (if any) and Out of Pocket Maximum in the same manner as a Copayment or Coinsurance.

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the drug is in.

- **Tier 1 Drugs** have the lowest Coinsurance or Copayment. This tier contains drugs that consist of most Generic Drugs and low-cost preferred Brand Name Drugs.
- **Tier 2 Drugs** have a higher Coinsurance or Copayment than those in Tier 1. This tier contains drugs that consist of non-preferred Generic Drugs; preferred Brand Name Drugs; and any other drugs recommended by Anthem's Pharmaceutical and Therapeutics (P&T) committee based on safety, efficacy and cost.
- **Tier 3 Drugs** have a higher Coinsurance or Copayment than those in Tier 2. This tier contains drugs that consist of non-preferred Brand Name Drugs; drugs that are recommended by Anthem's Pharmaceutical and Therapeutics (P&T) committee based on safety, efficacy and cost; or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- **Tier 4 Drugs** have a higher Coinsurance or Copayment than those in Tier 3. This tier contains drugs that consist of drugs that are biologics; drugs that the FDA or the manufacturer requires to be distributed through a Specialty Pharmacy; drugs that require the Member to have special training or clinical monitoring for self-administration (Self-Administered Drugs); or drugs that cost Us more than six-hundred dollars ($600) (net of rebates) for a one (1) month supply.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). We may cover one form of administration instead of another or put other forms of administration in a different tier.

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. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The Prescription 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 (1) drug over another by Our Members, and where proper, certain clinical economic reasons.

If You have a question regarding whether a drug is on the Prescription Drug List, please refer to Our web site at www.anthem.com/ca.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e. oral, injected, topical or inhaled) and may cover one (1) form of administration instead of another as Medically Necessary.

This Plan limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain Prescription Drugs if they

are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Name Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.anthem.com/ca.

Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List

If You or Your doctor believe You need an exception to a limit to a quantity, dose or frequency limitation, to step therapy, or need a Prescription Drug that is not on the Prescription Drug List, Your doctor must complete a uniform prior authorization form and return it to Us. You or Your doctor can get the form online at www.anthem.com/ca or by calling the number listed on the back of Your ID Card. We will grant the exception request if We agree that it is Medically Necessary and appropriate. We will make a coverage decision within seventy-two (72) hours of receiving Your request. If We approve the exception request, coverage will be provided for the duration of Your Prescription, including refills. If We deny the request, You have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within seventy-two (72) hours of receiving Your request. If the IRO approves the request, coverage will be provided for the duration of Your Prescription, including refills.

You or Your doctor 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 on the Prescription Drug List. We will make a coverage decision within twenty-four (24) 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 Prescription, including refills, or duration of the Prescription, including refills, or duration of the exigency, as applicable. 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 twenty-four (24) 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. The external exception review process is in addition to a Member's right to file a grievance or request an Independent Medical Review by the Department of Managed Health Care.

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

Drug Utilization Review

If there are patterns of over utilization or misuse of drugs, We will notify Your personal doctor and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of drugs.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost Share and Benefits." In most cases, You must use a certain amount of Your Prescription before it can be refilled. In some cases, We may let You get an early refill. For example, We may let You refill Your Prescription early if it is decided that You need a larger dose. We will work with the Pharmacy to decide when this should happen.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call Our PBM and ask for an override for one (1) early refill. If You need more than one (1) early refill, please call Pharmacy Member Services at the number on the back of Your Identification Card.

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 doctor tells You to take a "½ tablet daily." The half-tablet program is strictly

voluntary and You should talk to Your doctor about the choice when it is available. To get a list of the drugs in the program call the number on the back of Your Identification Card.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Partial Fill Program

A Pharmacist may dispense a Schedule II drug as a partial fill if requested by You or Your Provider. Anthem will prorate an enrollee's Cost Sharing for a partial fill of a Prescription of an oral, solid dosage form Prescription Drug. A Schedule II drug is a drug that has a high potential to result in severe dependence.

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. 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. You can access the list of these Prescription Drugs by calling the toll-free Pharmacy Member Services number on Your Member ID Card or log on to the Member web site 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 Prescription Drug List.

Rebate Impact on Prescription Drugs You Get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

Child Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is Medically or Dentally Necessary. The only exception is when You get orthodontic care — We do review those services to make sure they are appropriate.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery or braces — it is best to go over a care or treatment plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for Members until the end of the month in which they turn nineteen (19). All Covered Services are subject to the terms, limitations and exclusions of this Plan. See the "Schedule of Cost Share and Benefits" for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Diagnostic and Preventive Services

Oral Exams

- periodic oral exams are covered one (1) time per six (6) months
- limited oral exams are covered – problem focused
- oral evaluation for a patient under three (3) years of age and counseling with primary caregiver
- comprehensive oral exams are covered for new or established patients
- detailed and extensive oral exams are covered – problem focused, by report
- re-evaluation – Limited or problem focused are covered twelve (12) times per twelve (12) months, covered six (6) times per three (3) months for temporomandibular joint conditions
- re-evaluation – post operative office visit
- comprehensive periodontal evaluation for new or established patient

Radiographs (X-rays)

- complete full mouth series (including bitewings) are covered once per thirty-six (36) months
- periapicals (first radiographic image and each additional radiographic image) are covered twenty (20) per twelve (12) months
- intraoral – occlusal radiographic images are covered two (2) times per six (6) months
- extraoral 2D radiographic images are covered once per day
- extraoral posterior radiograph images are covered four (4) films per day
- bitewings (single film) are covered once per day
- bitewings (two (2) films) are covered once per six (6) months
- bitewings (three (3) films) are covered once per six (6) months
- bitewings (four (4) films) are covered once per six (6) months for Members age ten (10) and older
- vertical bitewings – seven (7) to eight (8) radiographic images are covered
- sialography
- temporomandibular joint arthrogram, including injection covered three (3) times per day
- tomographic survey covered twice per twelve (12) months
- panoramic film is covered once per thirty-six (36) months

Consultation with a Medical Health Examiner

Pulp Vitality Tests

Diagnostic Casts are covered as part of orthodontic care.

Dental Cleaning (prophylaxis child or adult). Procedure to remove plaque, tartar (calculus), and stain from teeth. If You have periodontal maintenance (see Basic Restorative Services later in this section), that will count as an instance towards the dental cleaning benefit frequency. Covered one (1) time per six (6) months.

Fluoride Treatment (topical application or fluoride varnish) is covered one (1) time per six (6) months.

Nutritional Counseling

Tobacco Counseling for the control and prevention of oral disease

Oral Hygiene Instructions

Dental Sealant Treatments are covered for first, second and third molars only. Covered one (1) time per tooth per thirty-six (36) months.

Preventive Resin Restoration

Sealant Repair(s) are covered for the first, second and third molars only. Covered one (1) time per tooth per thirty-six (36) months.

Caries Risk Assessment and Documentation (low, medium or high)

Other Oral Pathology Procedures (by report)

Space Maintainers (fixed and removable). Unilateral space maintainers are covered one (1) time per quadrant. Bilateral space maintainers are covered one (1) time per arch.

Re-cement Space Maintainers

Removal of Space Maintainer is covered only when performed by a Provider that did not initially place the appliance.

Distal Shoe Space Maintainer – fixed – unilateral

Unspecified Diagnostic Procedure(s) (by report)

Basic Restorative Services

Emergency Treatment (also called palliative treatment) is covered for the temporary relief of pain or infection. Covered one (1) time per day.

Fillings (restorations). Amalgam (silver colored) and composite (tooth-colored) fillings are covered under this Plan. Fillings on primary teeth are covered one (1) time per tooth per twelve (12) months. Fillings on permanent teeth are covered one (1) time per tooth per thirty-six (36) months.

Periodontal Maintenance is covered four (4) times per twelve (12) months and only twenty-four (24) months after scaling and root planing. If You have a dental cleaning (see Diagnostic and Preventive Services), it will count as an instance toward the periodontal maintenance benefit frequency.

Basic Extractions

- removal of coronal remnants (retained pieced of the crown portion of the tooth) on primary teeth
- extraction of erupted tooth or exposed root

Reattachment of Tooth Fragment – incisal edge or cusp

Pins and Pin Build-up is covered when given with a restoration service, such as a filling.

Sedative Fillings are covered one (1) time per six (6) months.

Interim Therapeutic Restoration – primary dentition

Restorative Foundation for an Indirect Restoration

Recement Inlay, Onlay or Partial Coverage Restoration are covered one (1) time per twelve (12) months.

Recement or Rebond Indirectly Fabricated or Prefabricated Post and Core

Recement or Rebond Crown. Covered twelve (12) months after initial placement of crown. Covered only when the procedure is completed by the same Provider that placed the crown.

Prefabricated Crowns

- porcelain/ceramic on primary tooth is covered one (1) time per twelve (12) months
- stainless steel crown on primary tooth is covered one (1) time per twelve (12) months
- stainless steel crown on permanent tooth is covered one (1) time per thirty-six (36) months
- resin on primary tooth is covered one (1) time per twelve (12) months and resin on permanent tooth is covered one (1) time per thirty-six (36) months
- stainless steel with resin window is covered one (1) time per twelve (12) months for a primary tooth and one (1) time per thirty-six (36) months for a permanent tooth

Core Buildup, including any pins when required

Post and Core (in addition to crown), Indirectly Fabricated. Covered once per tooth.

Each Additional Indirectly Fabricated Post, same tooth

Prefabricated Post and Core, in addition to crown

Post Removal

Each Additional Prefabricated Post, same tooth

Additional Procedure to Construct New Crown under existing partial dental framework.

Crown Repair necessitated by restorative material failure is covered twelve (12) months after initial placement or repair of the crown by the same Provider.

Unspecified Restorative Procedure, by report

Miscellaneous Services

- consultation provided by dentist or doctor other than requesting dentist or doctor
- house calls are covered one (1) time per day
- Hospital or Ambulatory Surgical Center call
- office visits are covered one (1) time per day
- therapeutic drug injections are covered four (4) times per day
- application of desensitizing medicament covered one (1) time per twelve (12) months
- treatment of complications (post surgical) or unusual circumstances are covered one (1) time per day and only within thirty (30) days of an extraction
- local anesthesia in and not in conjunction with operative or surgical procedures
- regional block anesthesia
- trigeminal division block anesthesia
- inhalation of nitrous oxide

- intravenous moderate (conscious) sedation/analgesia
- non-intravenous conscious sedation

Endodontic Services

Endodontic Therapy. The following will be covered one (1) time per tooth. Covered on permanent teeth only:

- root canal therapy
- root canal retreatment are covered twelve (12) months after the initial root canal therapy when given by the same Provider as the root canal therapy

Root Canal Obstruction

Internal Root Repair of Perforation Defects

Other Endodontic Treatments. Unless otherwise noted below, the following services are covered one (1) time per tooth.

- apexification first visit
- apexification – interim medication replacement
- apicoectomy, anterior, bicuspid, and molar(s) are covered ninety (90) days after a root canal therapy by the same Provider or twenty-four (24) months after apicoectomy/periradicular surgery by the same Provider
- therapeutic pulpotomy
- gross pulpal debridement
- partial pulpotomy for apexogenesis
- pulpal therapy – anterior or posterior tooth (excluding final restoration)
- unspecified endodontic procedure, by report

Pulp Cap – direct and indirect (excluding final restoration)

Apicoectomy, each additional root

Periradacular Surgery without apicoectomy

Retrograde Filling – per root

Surgical Procedure – isolate with rubber dam

Periodontal Services

Periodontal Scaling and Root Planing. One (1) to three (3) teeth or four (4) or more teeth are covered one (1) time per quadrant per twenty-four (24) months. Covered for Members age thirteen (13) and older.

Biologic Materials to aid Tissue Regeneration

Scaling in Presence of Generalized Moderate or Severe Gingival Inflammation – full mouth, after oral evaluation

Full Mouth Debridement

Chemotherapeutic Agents

Unscheduled Dressing Change, by someone other than treating dentist is covered one (1) time with gingivectomy/gingivoplasty, or osseous surgery.

Complex Surgical Periodontal Care

- gingivectomy/gingivoplasty for one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant or four (4) or more continuous teeth or tooth bounded spaces is covered one (1) time per quadrant per thirty-six (36) months on Members age thirteen (13) and older
- apically positioned flap
- crown lengthening
- osseous surgery for one (1) to three (3) contiguous teeth or tooth bounded spaces per quadrant or four (4) or more continuous teeth or tooth bounded spaces is covered one (1) time per quadrant per thirty-six (36) months on Members age thirteen (13) and older

Unspecified Periodontal Service, by report, is covered for Members age thirteen (13) and older.

Oral Surgery Services

Oral surgery services include post-operative care, such as examinations, removal of stitches, and treatment of post-surgical complications.

Complex Surgical Extractions. Surgical removal of third (3rd) molars is covered only when symptoms of pathology exists.

- surgical removal of erupted tooth
- surgical removal of impacted tooth – soft tissue, partially bony, completely bony, and completely bony with unusual surgical complications
- surgical removal of residual tooth roots

Other Oral Surgery Procedures are covered. Oral surgeries include, but are not limited to:

- biopsy of oral tissue (hard) are covered one (1) time per arch per day
- biopsy of oral tissue (soft) are covered three (3) times per day
- excision and removal of lesions, cysts and tumors
- frenulectomy (frenectomy or frenotomy) is covered one (1) time per arch per day
- incision and drainage of abscesses is covered one (1) time per quadrant per day
- removal of palatal torus and mandibular torus is covered one (1) time per quadrant per lifetime
- oroantral fistula closure
- sinus perforation – primary closure
- tooth reimplantation and/or stabilization of accidently evulsed or displaced tooth
- placement of device to facilitate eruption of impacted tooth
- sinus augmentation
- surgical reduction tuberosity is covered one (1) time per quadrant per lifetime
- sequestrectomy for osteomyelitis is covered one (1) time per quadrant per day and only after thirty (30) days has passed since an extraction

Intravenous Conscious Sedation, IV Sedation and General Anesthesia are covered when given with a covered complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services. Non-intravenous conscious sedation may be used for Members under thirteen (13) when they are uncooperative.

Local Anesthesia.

- covered in conjunction with operative or surgical procedures (such as filling, crowns, or oral surgery) but is not payable separately
- covered one (1) time per date of service when not in conjunction with operative or surgical procedures (such as a filling, crown or oral surgery) to perform a different diagnosis or as an injection to eliminate or control a disease or abnormal state

Nitrous Oxide is covered for Members under thirteen (13) when they are uncooperative. Covered only when given in a dental office by a Provider that is acting within the scope of their license.

Major Restorative Services

Permanent Crowns are covered one (1) time per sixty (60) months for Members age thirteen (13) and older. The following crowns are covered under this Plan:

- resin (lab procedure)
- ¾ resin-based composite (indirect)
- resin with predominantly base metal
- porcelain with ceramic substrate
- porcelain fused to predominately base metal
- ¾ cast predominately base metal
- ¾ porcelain/ceramic
- full cast predominately base metal

Restorative Cast Post and Core Buildup is covered one (1) time per tooth.

Additional Cast Post and Core Buildup, same tooth

Occlusal Guards are covered one (1) per twelve (12) months for Members ages thirteen (13) and up with temporomandibular joint disorders.

Occlusion Analysis, Occlusal Adjustment (limited and complete) – Each procedure covered once (1) per twelve (12) months for Members age thirteen (13) and up with temporomandibular joint disorders.

Prosthodontic Services – Removable

Complete and Partial Dentures are covered one (1) time per sixty (60) months for the replacement of extracted permanent teeth. If You have an existing denture or partial, a replacement is only covered if at least sixty (60) months has passed and it cannot be repaired or adjusted. Types of partial dentures covered are resin base and cast metal with resin base.

Immediate Dentures (upper and lower) are covered one (1) time per arch per lifetime.

Immediate Partial Dentures (upper and lower). The approved materials for immediate partial dentures are:

- resin based (including any conventional clasps, rests and teeth)
- cast metal framework with resin denture bases (including any conventional clasps, rests and teeth

Overdenture (complete and partial)

Relines. Chairside or laboratory relines are covered one (1) time per twelve (12) months following placement of a complete or partial denture without extractions. Covered one (1) time if six (6) months following placement of a complete or partial denture with extractions.

Repairs and Replacement of Broken Clasps are covered two (2) times per twelve (12) months per arch, up to three (3) clasps per visit. Covered once (1) if six (6) months have passed from initial placement.

Replace Missing or Broken Teeth are covered two (2) times per twelve (12) months per arch, up to four (4) teeth per visit. Covered once (1) if six (6) months have passed from initial placement.

Adding Tooth and Clasp to Existing Partial Denture is covered one (1) time per tooth per lifetime up to three (3) teeth per visit. Covered once six (6) months have passed from initial placement.

Denture and Partial Denture Adjustments are covered two (2) per twelve (12) months. Covered once (1) if six (6) months have passed from initial placement, reline or repair.

Denture (complete), Resin Denture Base, Cast Framework Repairs are covered two (2) times per twelve (12) months per arch. Covered once (1) if six (6) months have passed from initial placement.

Tissue Conditioning (upper and lower) is covered two (2) times each appliance per thirty-six (36) months.

Precision Attachment

Unspecified Removable Prosthodontic Procedure

Prosthodontic Services – Fixed

Bridges. This fixed prosthodontic appliance "bridges" the gap created by one (10)or more missing teeth. It involves creating a crown for the tooth or implant on either side of the missing tooth with a pontic in between. A bridge is covered one (1) time per sixty (60) months for the replacement of extracted permanent teeth. If You have an existing bridge, a replacement is only covered if at least sixty (60) months have passed and it cannot be repaired or adjusted. A bridge made of the following material(s) is covered under this Plan:

- porcelain fused to predominantly base metal
- porcelain ceramic
- resin with predominantly base metal
- cast predominantly base metal

In addition, the following retainer crown(s) made of the following material(s) is covered under this Plan:

- ¾ cast predominantly base metal
- ¾ porcelain ceramic
- full cast predominantly base metal

Bridge Adjustments and Repairs are covered twelve (12) months after initial placement or repair of crown by the same Provider.

Re-cementation of Bridge is covered twelve (12) months after initial placement of bridge. Covered only when given by the same Provider that placed the appliance.

Unspecified Fixed Prosthodontic Procedure

Implants Services

Surgical Placement of Implant Bodies including endosteal, mini, eposteal, and transosteal implants

Implant Supported Structures.

- semi-precision attachment
- prefabricated
- custom prefabricated

Implant/Abutment Supported Prosthetics including:

- connecting bar – implant supported or abutment supported
- prefabricated abutment – includes modification and placement
- custom fabricated abutment – includes placement
- abutment supported porcelain/ceramic crown
- abutment supported porcelain fused to metal crown (high noble metal)
- abutment supported porcelain fused to metal crown (predominantly base metal)
- abutment supported porcelain fused to metal crown (noble metal)
- abutment supported cast metal crown (high noble metal)
- abutment supported cast metal crown (predominantly base metal)

- abutment supported cast metal crown (noble metal)
- implant supported porcelain/ceramic crown
- implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
- implant supported metal crown (titanium, titanium alloy, high noble metal)
- abutment supported retainer for porcelain/ceramic FPD
- abutment supported retainer for porcelain fused to metal FPD (high noble metal)
- abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
- abutment supported retainer for porcelain fused to metal FPD (noble metal)
- abutment supported retainer for cast metal FPD (high noble metal)
- abutment supported retainer for cast metal FPD (predominantly base metal)
- abutment supported retainer for cast metal FPD (noble metal)
- implant supported retainer for ceramic FPD
- implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
- scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure
- provisional implant crown
- repair implant supported prosthesis, by report
- replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
- recement implant/abutment supported crown is covered; twelve (12) months after initial placement of crown by same Provider
- recement implant/abutment supported fixed partial denture (bridge) is covered; twelve (12) months after initial placement of crown by same Provider
- abutment supported crown – (titanium)
- repair implant abutment, by report
- implant removal, by report
- implant/abutment supported removable denture for edentulous arch – maxillary
- implant/abutment supported removable denture for edentulous arch – mandibular
- implant/abutment supported removable denture for partially edentulous arch – maxillary
- implant/abutment supported removable denture for partially edentulous arch – mandibular
- implant/abutment supported fixed denture for edentulous arch – maxillary
- implant/abutment supported fixed denture for edentulous arch – mandibular
- implant/abutment supported fixed denture for partially edentulous arch – maxillary
- implant/abutment supported fixed denture for partially edentulous arch – mandibular
- radiographic/surgical implant index, by report
- abutment supported retainer crown for FPD (titanium)
- unspecified implant procedure, by report

Alveoloplasty is covered in conjunction with extractions. Alveoplasty not in conjunction with extractions is covered after six (6) months of any extraction.

Vestibuloplasty is covered one (1) time per arch per sixty (60) months. Vestibuloplasty that includes grafts and/or muscle reattachment is covered one (1) time per arch per lifetime.

Facial Prosthetics. Facial prosthetics are covered under this Plan, including, but not limited to:

- facial moulage (sectional and complete)
- nasal
- auricular
- orbital
- ocular (permanent and interim)
- facial
- nasal septal
- cranial

- facial augmentation implant
- mandibular resection, with and without guide flange
- oburator (surgical, definitive and interim)
- speech aids are covered to age eighteen (18)
- palatal augmentation
- palatal lift (definitive and interim)
- obturator prosthesis (modification) is covered two (2) times per twelve (12) months

Facial Prosthetics Replacements – nasal, auricular, orbital, facial, obturator (surgical and definitive)

Additional Maxillofacial Procedures, includes:

- speech aids (modification) are covered two (2) times per twelve (12) months
- palatal lift (modification) is covered two (2) times per twelve (12) months
- trismus appliance (not for temporomandibular joint disorder treatment)
- feeding aids are covered to age eighteen (18)
- surgical splint
- surgical stent
- radiation carrier and shield
- radiation cone locater
- fluoride gel carrier
- commissure and surgical splint
- vesiculobullous disease medicament carrier
- unspecified maxillofacial prosthesis, by report

It is recommended that You get a pretreatment estimate for facial prosthetics so You fully understand the treatment and cost before having these services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Orthodontic care can be beneficial to generally prevent disease and promote oral health. Talk to Your dental Provider about getting a pretreatment estimate for Your orthodontic treatment plan, so You have an idea upfront what the treatment and costs will be. You or Your dental Provider should send it to Us so We can help You understand how much is covered by Your benefits.

Medically Necessary Orthodontic Care. This Plan will only cover orthodontic care when it is Medically Necessary to restore the form and function of the oral cavity, such as through the result of an injury or from dysfunction resulting from congenital deformities. To be considered Medically Necessary orthodontic care, at least one (1) of the following criteria must be present:

- spacing between adjacent teeth that interferes with Your biting function
- overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite
- the position of Your jaw or teeth impairs Your ability to bite or chew
- on an objective, professional orthodontic severity index (such as the HLD Index) or consistent with current California Denti-Cal orthodontic criteria, the condition scores at a level consistent with the need for orthodontic care

Orthodontic Treatment may include the following:

- pre-orthodontic treatment visits are covered one (1) time every three (3) months
- periodic treatment visits are covered four (4) times per Year
- comprehensive or complete treatment. A full treatment case that includes all radiographs (such as 2D cephalometric (two (2) films per twelve (12) months), 2D oral/facial images (four (4) per day), 3D photographic images, models, orthodontic appliances and office visits

- orthodontic retention is covered one (1) time per arch per course of treatment. Repair or replacement of lost or broken retainer is covered one (1) time per appliance. Replacement covered only within twenty-four (24) months of placement of the orthodontic retainer
- complex surgical procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth one (1) time per arch per lifetime, with orthodontia), transseptal fiberotomy one (1) time per arch per lifetime, with orthodontia)

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of Your treatment. In order for Us to continue to pay for Your orthodontic care, You must have continuous coverage under this Plan.

The first (1st) payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six (6) month intervals until the treatment is finished or coverage under this Plan ends. Your Cost Share for Medical Necessary orthodontic care applies to Your course of treatment, not individual benefit Years with a multi-Year course of treatment.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin coverage under this Plan, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that You are given while covered under this Plan. We will not pay for any portion of Your treatment that was given before Your Effective Date under this Plan.

What Orthodontic Care Does NOT include. Coverage is NOT provided for:

- monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment
- orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment
- retreatment and services given due to a relapse
- inpatient or Outpatient Hospital expenses, unless covered by the medical benefits of this Plan
- any provisional splinting, temporary procedures or interim stabilization of the teeth.

Child Vision Care

These vision care services are covered for Members until the end of the month in which they turn nineteen (19). To get In Network benefits, use a Blue View Vision eye care Provider. For help finding one, try “Find a Doctor” on Our web site or call Us at the number on Your Identification Card.

Routine Eye Exam with Refraction

This Plan covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of Your vision.

Eyeglass Lenses

Standard plastic (CR39) or glass eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28), progressive or lenticular. Polycarbonate lenses may be obtained at no extra cost.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the “Schedule of Cost Share and Benefits” for the list of covered lens options.

Frames

Your Blue View Vision Provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge — and which ones will cost You more.

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one (1) of those three (3) options in a given Year. Your Blue View Vision Provider will have a collection of various types of contact lenses for different eye conditions and prescriptions for You to choose from. They can tell You which contacts are included at no extra charge – and which ones will cost You more.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

- aniridia and aphakia
- 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
- for patients whose vision can be corrected three (3) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

Note: This is not an exhaustive list. Non-elective contacts may be prescribed for other conditions.

Note: We will not pay for non-elective contact lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when You have a significant loss of vision, but not total blindness. Your Plan covers services for this condition when You go to a Blue View Vision eye care Provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

In this section You will find a review of items that are not covered by Your Agreement. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by Your Agreement.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by Your Agreement.

The following services are not covered:

- services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital
- services by Out of Network Providers unless:
    - the services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
    - the services are approved in advance by Us.
- however, if You receive Covered Services at an In Network Facility at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Medical Services

Your Medical benefits do not cover:

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

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

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

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and trachea-esophageal voice devices approved by Us.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated
- allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain
- food allergy test panels (including SAGE food allergy panels)
- services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies
- specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's test), treatment of non-specific candida sensitivity, and urine autoinjections
- antigen leukocyte cellular antibody test (ALCAT)
- cytotoxic test
- HEMOCODE food tolerance system
- IgG food sensitivity test
- immuno blood print test
- leukocyte histamine release test (LHRT)

Alternative/Complementary Medicine. 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. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

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 doctor is not a Covered Service. Non-Covered Services for ambulance include, but are not limited to, trips to:

- a doctor'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 doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Artificial/Mechanical Devices - Heart Condition. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to ventricular assist devices used as a bridge to transplantation, or as a permanent alternative to heart transplantation, or the total artificial heart if the request meets Anthem medical policy criteria.

Autopsies and Postmortem Testing.

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 Not Supported by Medical Records. Charges for services not described in Your medical records.

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.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- any Investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments; 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.

Compound Drugs. Compound Drugs unless all the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA-approved Compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants as determined by the PBM.

Corrective Eye Surgery. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

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. This exclusion does not apply to services mandated by State or federal law, or as covered in the "What is Covered" sections (Medical, Prescription Drugs, Child Dental, Child Vision) of this Agreement.

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

Counseling Services. Counseling services and treatment related to 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. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Court Ordered Care. For court ordered testing or care, unless the service is Medically Necessary and authorized.

Custodial Care, Services/Care Other Facilities. We do not provide benefits for procedures, equipment, services, supplies or charges for the following, except as determined to be Medically Necessary for the

treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED):

- custodial care or assistance with activities for daily living (for example,: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine) except as part of Hospice Care, Skilled Nursing Facility or Inpatient Hospital care
- convalescent care or rest cures
- domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included
- care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Implants for Members age nineteen (19) and over. 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 except as specified in "Dental Care" in the "What is Covered" section.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Agreement. "Dental treatment" includes, but is not limited to, preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including, but not limited to:

- extraction, restoration and replacement of teeth
- medical or surgical treatments of dental conditions
- services to improve dental clinical outcomes

Dental X-Rays, Supplies and Appliances. For dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified in "Dental Services" or "Child Dental Care" in the "What is Covered" section. The only exceptions to this are for any of the following:

- transplant preparation
- initiation of an immunosuppressive
- direct treatment of acute traumatic injury, cancer, or cleft palate

Devices. Devices that are:

- not generally accepted under professional medical standards as being safe or effective even though they are approved by the FDA
- not approved by the FDA

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. 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 specified in the "Emergency Room," "Diabetes Services," "Home Care Services," "Hospice Care," "Hospital Services," "Medical Supplies, Durable Medical Equipment and Appliances," "Skilled Nursing Facility," "Surgery," "Urgent Care Services," or other Covered Services in the "What is Covered" section.

Doctor or Other Practitioners' Charges. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- doctor 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 doctor
- for membership, administrative, or access fees charged by doctors 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

Doctor Stand-by Charges. For stand-by charges of a doctor.

Drugs 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, Medications or Other Substances. Covered Services do not include drugs, medications or other substances that are not generally accepted under professional medical standards as being safe, effective or whose use is in question in current published peer-reviewed medical and pharmaceutical literature and evidence-based outcomes. This does not apply to FDA-approved drugs, medications or other substances.

Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Agreement or Us.

Drugs Over the Quantity Prescribed or Refills After One 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 Prescribed by Providers lacking qualifications/registrations/certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.

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). This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Durable Medical Equipment. Covered Services do not include durable medical equipment except as specified in “Medical Supplies, Durable Medical Equipment and Appliances” in the “What is Covered” section. Non-Covered Services or supplies include, but are not limited to:

- orthopedic devices, shoes or shoe inserts except as specified in “Medical Supplies, Durable Medical Equipment and Appliances” in the “What is Covered” section
- 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

Education/Training. For services, supplies, or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism or to diabetes education.

Exams - Research Screenings. For examinations relating to research screenings.

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

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

If the Member has a life-threatening or seriously debilitating condition and the requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See the “If You Have a Complaint or an Appeal” section for further details.

This exclusion does not apply to services covered in "Clinical Trials" in the "What is Covered" section 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 except as specified in "Vision Services" in the "What is Covered" section. 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 Members under age nineteen (19).

Foot Care – Routine. For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

- 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

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Agreement or as required by law.

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

Gynecomastia. For surgical treatment of gynecomastia.

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 doctor. This exclusion also applies to health spas.

Hearing Aids, including Bone-Anchored Hearing Aids. Hearing aids and hearing tests to determine their efficacy and hearing tests to determine an appropriate hearing aid, except as specified in "Preventive Care Services" in the "What is Covered" section. This exclusion does not apply to cochlear implants.

Home Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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 as specified in "Hospice Care" in the "What is Covered" section
- food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas
- personal comfort items

Hospice Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- services or supplies for personal comfort or convenience, including homemaker services
- food services, meals, formulas and supplements except as specified in "Hospice Care" or even if the food, meal, formula or supplement is the sole source of nutrition except as specified in "Diabetes Services" in the "What is Covered" section
- 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 Growth Hormone. Human growth hormone.

Incarceration. 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 a CPT (current procedural terminology) code that indicates an infertility related diagnosis, except as specified in "Maternity and Reproductive Services" in the "What is Covered" section.

In-vitro Fertilization (IVF) or Pre-implant Genetic Diagnosis (PGD) of Embryos. Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.

Medical Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Medicare. If You are entitled to Medicare Part A or enrolled in Medicare Part B, We will not provide benefits that are payable under Medicare, except as listed in this Agreement or as required by federal law, as described in the "Important Information About Your Coverage" section.

Missed/Cancelled Appointments. For missed or cancelled appointments.

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.

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-approved Drugs. Drugs not approved by the FDA.

Non-authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified in "Surgery," "Transgender Services," or "Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood" in the "What is Covered" section.

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified in "Emergency Care Services" in the "What is Covered" section. 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 doctor, except as specified in "Autism Services" in the "What is Covered" section

- for which a health care Provider license is not required

This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Non-prescription Lenses, Eyeglasses or Contacts. Any non-prescription lenses, eyeglasses or contacts.

Not Medically Necessary. Any services or supplies which are not Medically Necessary, mandated by State or federal law, or as covered in the "What is Covered" sections (Medical, Prescription Drugs, Child Dental, Child Vision) of this Agreement.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified in "Diabetes Services" or "Doctor (Physician) Visits" in the "What is Covered" section or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

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

Orthotic Devices. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- repair and replacement due to misuse, malicious breakage or gross neglect
- replacement of lost or stolen items

Out of Network Providers. Services from an Out of Network Provider except as specified in "Emergency Care Services" in the "What is Covered" section or the "How Your Claims are Paid" section.

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

Over-the-Counter. 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, except as specified in "Preventive Care Services" in the "What is Covered" section or as required by law. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Personal Care, Convenience and Mobile/Wearable Devices. 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 doctor. 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

- consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
- safety helmets for Members with neuromuscular diseases; or
- sports helmets

Physical Exams and Immunizations - Other Purposes. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Private Duty Nursing. Inpatient or Outpatient services of a private duty nurse unless provided by a Home Health Care Provider or a hospice Provider.

Provider Services. You get from Providers that are not licensed by law to provide Covered Services, as defined in this Agreement. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Reasonable and Customary Value. Any amounts in excess of the Reasonable and Customary Value for care rendered by an Out of Network Provider without a Referral from a PCP. See “Out of Network Provider” and “Reasonable and Customary Value” in the “Definitions” section.

Residential Accommodations to treat behavioral health conditions, except when provided in a Hospital or Residential Treatment Center and except when provided as Medically Necessary treatment for Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child.

Reversal of Sterilization. For reversal of sterilization.

Self-Help Training/Care. For self-help training and other forms of non-medical self-care, except as specified in “Diabetes Services” in the “What is Covered” section or as required by law. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Services Not Approved by the FDA. Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require 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 Services” and “Urgent Care Services” in the “What is Covered” section 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” in the “What is Covered” section

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.

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

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, vertebral axial decompression (Vax-D) and DRX9000. Cervical traction (over door) equipment is not excluded.

Surrogate Pregnancy. Services or supplies provided to a person not covered under the 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 specified in “Dental Services” or “Child Dental

Services" in the "What is Covered" section 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 as specified in "Dental Services" or "Child Dental Services" in the "What is Covered" section.

Telephone/Internet Consultations. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or except as specified in "Doctor (Physician) Visits" in the "What is Covered" section. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

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

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- gastric electrical stimulation
- hippotherapy
- intestinal rehabilitation therapy
- prolotherapy
- recreational therapy
- sensory integration therapy (SIT)

This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

- child care
- meals
- mileage within the medical transplant Facility city
- rental cars, buses, taxis, or shuttle service, 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 donor companion/caregiver, unless a minor
- return visits for the donor for a treatment of a condition found during the evaluation

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

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age nineteen (19).

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. For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Agreement. This exclusion includes 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. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, then this exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party. If We provide benefits for such injuries, conditions or diseases, We shall be entitled to establish a lien of other recovery under California Labor Code or any other applicable law.

Prescription Drugs

Your Prescription Drug benefits for Prescription Drugs purchased at a Retail, Home Delivery, or Specialty Pharmacy do not cover:

- Administration Charges for the Administration of any Drug except for covered immunizations as approved by Us or the PBM.
- An Allergenic Extract or Vaccine.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- Compound Drugs. Compound Drugs unless all the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to the non-FDA approved Compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants as determined by the PBM.
- 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.
- Cosmetic Services. Prescription Drugs given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how You look. This exclusion does not apply to services mandated by State or federal law.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs, Medications or Other Substances. Covered Services do not include drugs, medications or other substances that are not generally accepted under professional medical standards as being safe, effective or whose use is in question in current published peer-reviewed medical and pharmaceutical literature and evidence-based outcomes. This does not apply to FDA-approved drugs, medications or other substances.
- Drugs Not Approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Agreement or Us.
- Drugs Over the Quantity Prescribed or Refills After One 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 Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
- 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 State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Gene Therapy as well as any drugs, procedures, health care services related to it that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Lost or Stolen Drugs. Refills of lost or stolen drugs.

- Mail Service Programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any mail service program other than the PBM's Home Delivery mail service, unless We must cover them by law.
- 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. This exclusion does not apply to the Medically Necessary treatment of Severe Mental Illness (SMI) of a person of any age or Serious Emotional Disturbances of a Child (SED).
- Onychomycosis Drugs. Drugs for onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be Covered. Drugs, devices and products, or Legend Drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device or product. This includes Prescription Legend Drugs when any version or strength becomes available over-the-counter. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Prescription Drugs used to Treat Infertility.
- 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 We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight Loss Drugs. When prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. Enrollment in a comprehensive weight loss program may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

Child Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental care for Members age nineteen (19) and older, except as specified in “Dental Services” in the “What is Covered” section.
- Dental services or health care services not specifically covered under the Plan (including any Hospital charges, Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, except as specified in “Dental Services” or “Child Dental Care” in the “What is Covered” section.
- Services of Anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental Services, Appliances or Restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental Services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case Presentations, office visits, consultations.
- Incomplete Services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel Microabrasion and Odontoplasty.
- Biological tests for determination of periodontal disease or pathologic agents, except as specified in “Dental Services” or “Child Dental Care” in the “What is Covered” section.
- Collection of Oral Cytology Samples via scraping of the oral mucosa, except as specified in “Dental Services” or “Child Dental Care” in the “What is Covered” section.
- 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), stress breakers and precision attachments.
- Provisional Splinting, Temporary Procedures or Interim Stabilization.
- Pulp Vitality Tests.
- Adjunctive Diagnostic Tests.
- Cone Beam Images.
- Anatomical Crown Exposure.
- Temporary Anchorage Devices.
- Oral Hygiene Instructions when billed separately, as this is part of the oral exam benefit.
- Repair or Replacement of Lost or Broken Appliances.
- Removal of Pulpal Debridement, Pulp Cap, Post, Pins, Resorbable or Non-resorbable Filling Materials, nor the procedures used to prepare and place materials in the canals (tooth roots).

- 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.
- For Dental Services received prior to the Effective Date of this Agreement or received after the coverage under this Agreement has ended.
- Dental Services given by someone other than a licensed Provider (dentist or doctor) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), except as specified in “Dental Services,” “Doctor (Physician) Visits,” or “Child Dental Care” in the “What is Covered” section.
- Dental Services for which You would have no legal obligation to pay in the absence of this or like coverage.
- 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 a 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.
- Local Anesthetic when billed separately from Covered Services, as this is included as part of the final services, such as for restorative services (fillings, crowns).

Child Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for Members age nineteen (19) and older, except as specified in “Vision Services” in the “What is Covered” section.
- 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 a 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.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member’s immediate family, including the Member’s spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- 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, including Inpatient or Outpatient Hospital vision care, except as specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified in “Vision Services” or “Child Vision Care” in the “What is Covered” section.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

HOW YOUR CLAIMS ARE PAID

This section describes how Your claims are administered, explains the Cost Sharing features of Your Plan, and outlines other important provisions. The specific Cost Sharing features, and the applicable benefit percentages and/or limitations are outlined in the "Schedule of Cost Share and Benefits" section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Cost Sharing Requirements

Cost Sharing is how Anthem shares the cost of health care services with You. It means what Anthem is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Deductibles and/or Coinsurance (as described below).

Anthem works with doctors, Hospitals, Pharmacies and other health care Providers to control health care costs. As part of this effort, most Providers who contract with Anthem agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with Providers.

The contracts between Anthem and Our In Network Providers include a "hold harmless" clause which provides that You cannot be held responsible by the Provider for claims owed by Anthem for health care services covered under this Plan.

Covered Services that are not obtained from a PCP, SCP or another In Network Provider, or that are not Authorized Services will not be covered. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Coinsurance

Coinsurance means the percentage of the Maximum Allowed Amount for which You are responsible for a specified Covered Service. For example, if Your Coinsurance percentage listed on Your "Schedule of Cost Share and Benefits" is 20%, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan's benefit design.

Coinsurance amounts satisfied in a Benefit Year count towards the Out of Pocket Maximum.

Deductibles

Please refer to the "Schedule of Cost Share and Benefits" for services that do not apply to the Deductible. Coinsurance amounts You pay for Child dental and vision services apply toward Your medical Deductible.

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. No one (1) individual Member can contribute more than their individual Deductible amount. 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 "Schedule of Cost Share and Benefits."

The enrollment of newborn or adopted children will cause the applicable Deductible to change from an Individual Deductible to a Family Deductible. Additional information on newborn or adopted children is explained under "When Membership Changes (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 Your Deductible is not satisfied, We will apply only the allowed per visit or per day amount, whichever applies, toward Your Deductible.

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

Out of Pocket Maximums

The Out of Pocket Maximum includes all Deductibles and Coinsurance 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.

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 Prescription Drug List, but are approved by Anthem as exceptions will accumulate towards the In Network Out of Pocket Maximum.

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. No one (1) individual Member can contribute more than their individual 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 "Schedule of Cost Share and Benefits."

The enrollment of newborn or adopted children will cause the applicable Out of Pocket Maximum to 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 "When Membership Changes (Eligibility)."

Reminder: Carry Your 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.

Once the Out of Pocket Maximum is satisfied, no additional Cost Sharing will be required for the remainder of the Benefit Year.

Note: You should keep the itemized bills from Your doctors to track Your out-of-pocket expenses. These itemized bills should not be submitted to Us unless:

1. You are seeking reimbursement for In Network services, and
2. if an In Network Provider did not submit the claim; or
3. if You disagree with Our calculation of Your out-of-pocket expenses.

Out of Pocket Maximum Exceptions

Please read this section very carefully. Not all money that You pay toward Your health care costs are counted toward Your Out of Pocket Maximum.

Amounts You incur towards Your Deductibles and/or Coinsurance count towards the Out of Pocket Maximum. However, the following will never count towards the Out of Pocket Maximum, nor will they ever be paid under this Plan:

- amounts over any Plan maximum or limitation; and/or
- expenses for services not covered under this Plan.

Liability of Subscriber to Pay Providers

By statue and 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.

Benefit Period Maximum

Some Covered Services have a maximum number of days or visits that Anthem will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out of Pocket Maximum. See the "Schedule of Cost Share and Benefits" for those services which have a Benefit Limit.

Balance Billing

In Network Providers are prohibited from balance billing. An In Network Provider has signed an agreement with Anthem to accept Our determination of the Maximum Allowed Amount or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Plan, e.g., Deductibles (if any) or Coinsurance. When You receive Covered Services from an Out of Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant. However, if You receive Covered Services at an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the Cost Sharing for the same Covered Services received from an In Network Provider.

Maximum Allowed Amount

General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by In Network and Out of Network Providers is based on Your Plan's Maximum Allowed Amount for the Covered Service that You receive. Please also see "Inter-Plan Programs" provision for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement We will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Precertification, Utilization Review, or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out of Network Provider under this Plan are not covered except for Emergency care, or when services have been previously authorized by Us. When You receive Covered Services from an Out of Network Provider You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. However, if You receive Covered Services at an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the Cost Sharing for the same Covered Services received from an In Network Provider.

When You receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same doctor or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

An In Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In Network Provider, the Maximum Allowed Amount for Your Plan is the rate the Provider has agreed with Us 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 for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In Network Provider or visit Our web site www.anthem.com/ca.

Providers who have not signed any contract with Us and are not in any of Our networks are Out of Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. If You use an Out of Network Provider, Your entire claim will be denied except for Emergency care, or unless the services were previously authorized by Us.

For Covered Services You receive in an Emergency or if previously authorized from an Out of Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Us:

1. an amount based on Our Out of Network fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one (1) or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. 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; or
3. an amount based on information provided by a third party vendor, which may reflect one (1) or more of the following factors: 1) the complexity or severity of treatment; 2) level of skill and experience required for the treatment; or 3) comparable Providers’ fees and costs to deliver care; or
4. an amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. an amount based on or derived from the total charges billed by the Out of Network Provider.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out of Network. For this Plan the Maximum Allowed Amount for services from these Providers will be one (1) of the five (5) methods shown above unless the contract between Anthem and that Provider specifies a different amount.

For services rendered outside Anthem’s Service Area by Out of Network Providers, claims may be priced using the local Blue Cross and/or Blue Shield plan’s nonparticipating provider fee schedule/rate or the pricing arrangements required by applicable State or federal law. In certain situations, the Maximum Allowed Amount for out-of-area claims may be based on billed charges, the pricing We would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In Network Providers, Out of Network Providers may send You a bill and collect for the amount of the Provider’s charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In Network Provider will likely result in lower out-of-pocket costs to You. Please call Member Services for help in finding an In Network Provider or visit Our web site at www.anthem.com/ca. However, if You receive Covered Services at an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the Cost Sharing for the same Covered Services received from an In Network Provider.

Member Services is also available to assist You in determining Your Plan’s Maximum Allowed Amount for a particular service from an Out of Network Provider. In order for Us to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the

Provider will render. You will also need to know the Provider's charges to calculate Your out-of-pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using Prescription Drug cost information provided by the PBM.

Member Cost Share

For certain Covered Services and depending on Your Plan design, You may be required to pay a part of the Maximum Allowed Amount as Your Cost Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Please see Your "Schedule of Cost Share and Benefits" for Your Cost Share responsibilities and limitations, or call Member Services toll free at the telephone number on the back of Your Identification Card to learn about this Plan's benefits or Cost Share amounts.

We will not provide any reimbursement for non-Covered Services. You will 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 or Out of Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your day/visit limits.

SERVICES MUST BE PERFORMED OR SUPPLIES FURNISHED BY AN IN NETWORK PROVIDER IN ORDER FOR BENEFITS TO BE PAYABLE. There are no benefits provided when using an Out of Network Provider and You may be responsible for the total amount billed by an Out of Network Provider, except for services received by an Out of Network Provider as a result of a Medical Emergency, Urgent Care services received at an Urgent Care Center or an Authorized Referral as defined in "Definitions." Additionally, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider.

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 from a Provider who is not an In Network Provider under this Plan care are considered Out of Network services and are not covered and You may be responsible for the total amount billed by an Out of Network Provider, except for an Emergency, Urgent Care services received at an Urgent Care Center or for a service pre-approved as an Authorized Service even if You have been referred by another Anthem In Network Provider. Additionally, if You receive Covered Services from an In Network Facility at which, or as a result of which, You receive services from an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services from an In Network Provider.

In some instances You may only be asked to pay only the lower In Network Cost Share amount when You use an Out of Network Provider. For example, if You receive services from an In Network Hospital or Facility at which, or as a result of which, You receive nonemergency Covered Services from an Out of Network Provider such as a radiologist, anesthesiologist or pathologist providing services at the In Network Hospital or Facility, You will pay no more than the same Cost Sharing that You would pay for those Covered Services received from an in Network Provider, and You will not owe the Out of network Provider more than the In Network Cost Sharing for such nonemergency Covered Services.

Authorized Services

In some circumstances, such as where there is no In Network Provider available for the Covered Service, We may authorize the In Network Cost Share amounts (Copayment and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out of Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the In Network Cost Share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out of Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize an In Network Cost Share amount to apply to a Covered Service received from an Out of Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out of Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization. If You receive services from an In Network Facility at which, or as

a result of which, You receive nonemergency Covered Services provided by an Out of Network Provider, You will pay the Out of Network Provider no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider. See “Member Cost Share” above for more information.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever You access healthcare services outside the geographic area We serve (the “Anthem Service Area”), the claim for those services may be processed through one (1) of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Anthem Service Area, You will receive it from one (1) of two (2) kinds of Providers. Most Providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield plan in that geographic area (“Host Blue”). Some providers (“nonparticipating providers”) do not contract with the Host Blue. We explain below how We pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

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

When You receive 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 charges for Covered Services; or
- the negotiated price that the Host Blue makes available to Us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. 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 pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Services under a value-based program inside a Host Blue’s Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these

fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or State laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by nonparticipating providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable State or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the nonparticipating provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or State law, as applicable, will govern payments for Out of Network Emergency Services.

2. Exceptions

In certain situations, We may use other pricing methods, such as billed charges the pricing We would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount We will pay for services provided by nonparticipating providers. In these situations, You may be liable for the difference between the amount that the nonparticipating provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. Blue Cross Global® Core Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Global® Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care services outside of 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 Blue Cross Global® Core 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.

Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care. Please refer to the "Requesting Approval for Benefits" section.

How Claims are Paid with Blue Cross Global® Core

In most cases, when You arrange Inpatient Hospital care with Blue Cross Global® Core, 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 typically need to pay for the following services up front:

- doctors services;
- Inpatient Hospital care not arranged through Blue Cross Global® Core; and
- Outpatient services.

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

Additional information on Blue Cross Global® Core 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 Blue Cross Global® Core claim forms You can get international claims forms in the following ways:

- call the Blue Cross Global® Core service center at the numbers above; or
- online at www.bcbsglobalcore.com.

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

Notice of Claim

When using an In Network Provider, the Provider 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.

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 Filing for Out of Network Emergency Services

If Emergency Services are provided by an Out of Network Provider, the Provider may bill Us directly for the services, and Your claim will be processed as required by law. The Out of Network Provider will be paid the Reasonable and Customary Value for such services. You are not responsible for amounts that exceed the applicable Cost Share for Emergency Services.

Time Benefits Payable

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.

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within thirty (30) working days for clean claims. "Clean claim" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If We fail to pay or deny a clean claim in thirty (30) working days, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under CA law.

Claim Denials

If benefits are denied, in whole or in part, Anthem will send the Member a written notice within the established time periods described in the section “Time Benefits Payable.” The Member or the Member’s duly authorized representative may appeal the denial as described in the “If You Have a Complaint or an Appeal” section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim Appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational Procedures or a similar limitation is available to the Member upon request and at no charge.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to Us, or contact Member Services and ask for a claims form to be sent to You. If You do not receive the claims form, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- name of patient
- patient's relationship with the Member
- identification number
- date, type, and place of service
- Your signature and the Provider's signature

Where to Send Your Claim

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

Member's Cooperation

You will be expected to complete and submit to Us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation, or any other governmental program. If You fail to cooperate, You will be responsible for any charge for services.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for benefits.

You authorize Us to make payments directly to Providers for Covered Services. In no event, however, shall Our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under this Agreement. We reserve the right to make payments directly to You as opposed to any Provider for Covered Service, at Our discretion. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out of Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Subscriber's Agreement), or that person's custodial parent or designated representative. Any payments made by Us (whether to any Provider for Covered Service or You) will discharge Our obligation to pay for Covered Services.

Once a Provider performs a Covered Service, We will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under this Agreement are not assignable by any Member without the written consent of Anthem. This prohibition against assignment includes rights to receive payment, claim benefits under this Agreement and/or law, and sue or otherwise begin legal action. Any assignment made without written consent from Anthem will be void and unenforceable.

Assignment

Members cannot legally transfer the coverage. Benefits available under this Plan are not assignable by any Member without obtaining written permission from Us, unless in a way described in this Plan.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received
- the amount of the charges satisfied by Your coverage
- the amount for which You are responsible (if any)
- general information about Your Appeals rights and for information regarding the right to bring an action after the Appeals process

Payment Owed to You at Death

Upon the death of a Member, claims will be payable in Our discretion to either the Member's estate or a beneficiary designated to Us. If the Provider is an In Network Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from nonparticipating or Out of Network Providers could be billed by the nonparticipating/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.

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 health care 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).

Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the Benefit Year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

IF YOU HAVE A COMPLAINT OR AN APPEAL

This section has information on how You can request review in the event that Your Agreement is terminated, cancelled or not renewed or address concerns or dissatisfaction about Your medical care or Our coverage decisions. Information on filing a complaint regarding discrimination based on race, color, national origin, age, disability, or sex can be found in the Language Assistance Services section of this Agreement.

If You have a question about Your eligibility, Your benefits under this Agreement, or concerning a claim, please call Member Services at 1-855-634-3381, or You may write to Us. Please address Your correspondence to:

Anthem Blue Cross
Attn: Member Services Department
P.O. Box 9051
Oxnard, CA 93031-9051

Our Member Services staff will answer Your questions or assist You in resolving Your issue.

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 cancelled, terminated, rescinded or not renewed. For additional information on these rights contact Member Services.

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 Member Services at 1-855-634-3381, 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 Our decision and Your right to also seek a further review of Our 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 Us or after You have received Our decision on Your Request for Review.

Dental Coverage Appeals

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

Anthem Blue Cross
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

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

Blue View Vision
555 Middle Creek Parkway
Colorado Springs, CO 80921

Prescription Drug Exception Request

Please refer to “Exception Request for a Quantity, Dose or Frequency Limitation, Step Therapy, or a Drug not on the Prescription Drug List” in “Prescription Drugs” under ”What is Covered” the process for submitting an exception request for drugs not on the Prescription Drug List.

Grievances

“Grievance” means a written or oral expression of dissatisfaction regarding Anthem 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 Anthem is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

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 Member Services representative to complete the form for You over the telephone. You may also submit a grievance form online at www.anthem.com/ca > Customer Support > “File an appeal or grievance” or mail it to the following address:

Anthem
Attn: Grievances and Appeals
P.O. Box 4310
Woodland Hills, CA 91365-4310

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 ID 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” below. 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** or at the TDD line **1-866-333-4823** for the hearing and speech impaired 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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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 doctor 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 doctor, or a board certified or board eligible doctor 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 doctor, 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 twenty-four (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 doctor. 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 doctor 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 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 Member Services 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

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced no earlier than sixty (60) days after We receive the claim or other request for benefits and within three (3) Years of Our final decision on the claim or other request for benefits. If We decide an Appeal is untimely, Our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust Our internal Appeals process before filing a lawsuit or other legal action of any kind against Us.

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Agreement are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

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

1. be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2. be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan.
3. be a United States citizen or national; or
4. be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. be a resident of the State of California and meet the following applicable residency requirements:
    - for a Qualified Individual age twenty-one (21) and over, the applicant must:
        - not be living in an institution;
        - be capable of indicating intent;
        - not be receiving optional State supplementary payments (SSP); and
        - reside in the Service Area applicable to this Agreement.
    - for a Qualified Individual under age twenty-one (21), the applicant must:
        - not be living in an institution;
        - not be emancipated;
        - not be receiving optional State supplementary payments (SSP); and
        - reside in the Service Area applicable to this Agreement.
6. agree to pay for the cost of the Premium that Anthem requires;
7. reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. not be incarcerated (except pending disposition of charges);
9. not be entitled to or enrolled in Medicare Parts A/B, C and/or D;
10. not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's Service Area is the area in which the Qualified Individual:

1. resides, intends to reside (including without a fixed address); or
2. is seeking employment (whether or not currently employed); or
3. has entered without a job commitment.

For Qualified Individuals under age twenty-one (21), the Service Area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. if all of the members of a tax household are not living within the same Exchange Service Area, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. if both spouses or domestic partners in a tax household enroll in a QHP through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange or

through the Exchange that services the area in which the Dependent meets residency requirements.

Dependent Eligibility

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. the Subscriber's legal spouse
2. the Subscriber's domestic partner - domestic partners are two (2) adults who meet the qualifications of State law. For purposes of this Agreement, a domestic partner shall be treated the same as a spouse
3. the Subscriber's or the Subscriber's spouse's or the Subscriber's domestic partner's children who are under age twenty-six (26), including stepchildren, newborn and legally adopted children
4. children for whom the Subscriber, the Subscriber's spouse or Subscriber's domestic partner is a legal guardian and who are under age twenty-six (26)

An enrolled Dependent child who reaches age twenty-six (26) during a benefit Year may remain enrolled as a Dependent until the end of that benefit Year. The Dependent coverage shall end on the last day of the benefit Year during which the Dependent child becomes ineligible.

Eligibility will be continued past the age limit only for those already enrolled Dependents who meet and continue to meet both of the following criteria:

1. is incapable of self-sustaining employment by reason of intellectual or physical impairment, and
2. is chiefly dependent upon the Subscriber for support and maintenance.

These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse or the Subscriber's domestic partner. The Dependent's impairment must start before the end of the period he or she would become ineligible for coverage.

The Exchange or Anthem Blue Cross acting on the Exchange's behalf must certify the Dependent's eligibility. The Exchange or Anthem Blue Cross acting on the Exchange's behalf must be informed of the Dependent's eligibility for continuation of coverage within sixty (60) days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage. The Exchange may require the Subscriber to submit proof of continued eligibility for any Dependent to the Exchange or to Anthem Blue Cross acting on the Exchange's behalf. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Agreement.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has sixty (60) calendar days from the date of a triggering event to select a QHP.

The following are triggering events for a special enrollment period:

- a Qualified Individual or Dependent loses Minimum Essential Coverage;
- a Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or through a child support court order (see “Court Ordered Health Coverage” below);
- an individual is mandated to be covered as a Dependent pursuant to a valid State or federal court order (see “Court Ordered Health Coverage” below);
- an individual has been released from incarceration;
- a Qualified Individual loses a Dependent or is no longer considered a Dependent through divorce, legal separation, or dissolution of domestic partnership as defined by State law in the State in which the divorce, legal separation, or dissolution of domestic partnership occurs, or if the individual, or his or her Dependent, dies;
- a Qualified Individual or Dependent newly meets the following requirements:
    - an applicant shall be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, or not previously a citizen, national, or lawfully present gains such status or a non-citizen who is lawfully present for the entire period for which enrollment is sought,
    - an applicant shall not be incarcerated, other than incarceration pending the disposition (judgment) of charges,
- an individual receiving services from a contracting Provider under another health benefit plan where that Provider is no longer participating in the health benefit plan may qualify for special enrollment;
- a Qualified Individual’s enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- an enrollee or Dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- a Qualified Individual, or Dependent enrolled in the same QHP, is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer’s upcoming Plan Year are permitted to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- a Qualified Individual, enrollee, or Dependent gains access to new QHPs as a result of a permanent move; provided he or she had Minimum Essential Coverage in effect for one (1) or more days of the sixty (60) days prior to the move;

- a Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide;
- an individual is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty (also see "Reinstatement of Coverage for Members of the Military" below);
- a Qualified Individual or Dependent is enrolled in any non-calendar Year group health plan or individual health insurance coverage, even if the Qualified Individual or their Dependent has the option to renew such coverage (the date of the loss of coverage is the last day of the plan or policy Year);
- a Qualified Individual or Dependent who loses pregnancy-related coverage or loses access to health care services through coverage provided to a pregnant woman's unborn child may qualify for a special enrollment (the date of the loss of coverage is the last day the Qualified Individual would have pregnancy-related coverage or access to health care services through the unborn child coverage);
- an individual who loses medically needy coverage may qualify for a special enrollment only once per calendar Year (the date of the loss of coverage is the last day the consumer would have medically needed coverage);
- a Qualified Individual or enrollee who is a victim of domestic abuse or spousal abandonment or is a Dependent or unmarried victim within a household, is enrolled in Minimum Essential Coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment may qualify for a special enrollment;
- a Qualified Individual who is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;
- the Qualified Individual or enrollee, or their Dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, Service Area, or Premium influenced the Qualified Individual's or enrollee's decision to purchase a QHP through the Exchange; or
- a member of a federally recognized American Indian tribe may enroll at any time and may change plans once per month.

If You cannot find Your situation or if You have questions regarding qualification for a special enrollment period, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

Newborn and Adopted Child Coverage

Newborn (recently born infants within thirty-one (31) days of birth) and adopted (children whose birth parent or appropriate legal authority have 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) children of the Subscriber, the Subscriber's spouse or the Subscriber's domestic partner will be covered for an initial period of thirty-one (31) days from the date of birth or adoption. To continue coverage beyond the first thirty-one (31) days, please contact the Exchange within sixty (60) days of the date of birth to add the child to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

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.

Please contact the Exchange within sixty (60) days of the placement for adoption or date of adoption to add the child to the Subscriber's Agreement and You must pay Anthem timely for any additional Premium due.

Newborn and adopted children of the Subscriber's Dependent children, newborn and adopted children of the Subscriber's spouse's Dependent children, or newborn and adopted children of the 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 Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse or the Subscriber's domestic partner files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Agreement must be submitted to the Exchange 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.

Court Ordered Health Coverage

If You are required by a 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, You must request permission from the Exchange for Your child to enroll under this Agreement and once approved by the Exchange, 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. 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.

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 Member Services at 1-855-634-3381 for information on how to apply for reinstatement of coverage following active duty as a reservist.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to Anthem.

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 unless the Subscriber timely requests a different Effective Date. Advance Payments of the Premium Tax Credit and Cost Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month;
2. in the case of marriage or domestic partnership coverage is effective on the first day of the month after receipt of the application, as long as the application is received within sixty (60) days of the event; and
3. in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within sixty (60) days of the qualifying event.

Effective Dates for special enrollment due to 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;
6. individual who no longer resides, lives or works in the Plan's Service Area;
7. a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. termination of employer contributions; or
9. Exhaustion of COBRA benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include 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 the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under: this Agreement. The Exchange 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, changes in income, change of Dependent's impairment or dependency status. Failure to notify the Exchange 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. The Exchange must be notified when the Member becomes eligible for or enrolled in Medicare.

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

Statements and Forms

Subscribers or applicants for Membership shall complete and submit to the Exchange applications or other forms or statements the Exchange 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 the Exchange is true, correct and complete and understand that all rights to benefits under this Agreement are subject to the condition that all such information is accurate. 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.

Moving out of the Service Area

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 plan with an In Network Provider in Your new Service Area.

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 "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 (the first day of the Agreement period for which the Premium is paid).

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

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com/ca
- by mail using the address on Your Premium notice
- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- pay in person at any approved retailers found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back Your Identification Card.

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 EFT which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, 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 the Exchange;
2. the Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, moves outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. the Member fails to pay his or her Premium, and the grace period has been exhausted.
4. rescission of the Member's coverage;
5. the QHP terminates or is decertified;
6. the Member changes to another QHP; or
7. the QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace period" refers to a thirty-one (31) day period beginning no earlier than the first day after the last date of paid coverage to allow a Member who does not receive Advance Payments of the Premium Tax Credit (APTC Member) to pay an unpaid Premium amount without losing healthcare coverage.

"Federal grace period" refers to the period of three (3) consecutive months a Qualified Health Plan must provide to an APTC Member, prior to terminating the Member's coverage for non-payment of Premium. To qualify for the federal grace period, the APTC Member must have paid at least one (1) full month's Premium during the Benefit Year.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
    a. the termination date specified by the Member, if reasonable notice is provided;
    b. fourteen (14) days after the termination is requested, if the Member does not provide reasonable notice; or
    c. on a date determined by the Member's QHP Issuer, if the Member's QHP Issuer is able to implement termination in fewer than fourteen (14) days and the Member requests an earlier termination Effective Date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination Effective Date.
4. In the case of a termination for non-payment of Premium and the three (3) month federal grace period for Members receiving Advance Payments of the Premium Tax Credit has been

exhausted, the last day of coverage will be the last day of the first month of the three (3) month federal grace period.

5. In the case of a termination for non-payment of Premium, and the individual is not receiving Advance Payments of Premium Tax Credit, the last day of coverage is the last day of the grace period.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or domestic partner of the deceased Subscriber, if covered under the Agreement, shall become the Subscriber.

"Reasonable notice" is defined as fourteen (14) days prior to the requested Effective Date of termination.

Guaranteed Renewable

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

1. Eligibility criteria as a Qualified Individual continue to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Agreement.
3. This Agreement has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP Issuer any information requested regarding Your eligibility and the eligibility of Your Dependents. 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 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.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three (3) month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Agreement is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one (1) month's Premium in a Benefit Period, We must provide a federal grace period of at least three (3) consecutive months. During the federal grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the federal grace period, the last day of coverage will be the last day of the first month of the three (3) month federal grace period. We must pay claims incurred during the first month of the three (3) month federal grace period. During the second and third month of the grace period Your coverage will be suspended and You will be ineligible for benefits under Your health benefit Plan unless You pay all Premiums due before the end of the federal grace period. You may be required by Your health care Providers to pay for any health care services You need.

Please note, that if Your full Premium payment is not received during the grace period You will have no coverage for claims incurred after the first month of the three (3) month federal grace period and this means You will be liable for the full cost of any services You receive after the first month of the three (3) month federal grace period. If You do not pay Your full Premium during the federal grace period, You will be liable to Us for the Premium payment due for the period through the last day of the first month of the three (3) month federal grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three (3) month federal grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Agreement has a grace period of thirty-one (31) days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. 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 for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the grace period.

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.

Removal of Members

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

Refund of Premium

Upon termination, We shall return promptly the unearned portion of any Premium paid.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

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 doctor, You and Your family.

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

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 doctor 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.

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 prior to the renewal of this Agreement. Any such change will apply to Premiums due on or after the renewal date. If advance Premiums have been paid beyond the renewal date, such Premiums will be adjusted as of the renewal date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Confidentiality and Release of Information

Applicable State and federal law requires Us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing Our policies and procedures regarding the protection, use and disclosure of Your medical information is available on Our web site and can be furnished to You upon request by contacting Our Member Services department.

Obligations that arise under State and federal law and policies and procedures relating to privacy that are referenced but not included in this Agreement are not part of the Agreement between the parties and do not give rise to contractual obligations.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

Notice of Privacy Practices

You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling Member Services at 1-855-634-3381 or by accessing Our web site at www.anthem.com/ca.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

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 the benefit "Child Dental Care" under "What is Covered."

If You are eligible for dental benefits through two (2) or more Plans, one (1) 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.

- 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.
- If the spouses or domestic partners both have separate dental Plans, each offering coverage for spouse or domestic partner 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.
- 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.
- If one of the Plans does not have a COB provision, it will be primary carrier.
- As required by law, if a covered Member of Your family also has coverage under Medicaid, this Plan is always primary.
- If Dependent children are covered under both Plans, one of the following rules will apply, unless there is a court order stating otherwise:
    - 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
    - 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 Plan 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.

Coordination with Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among State law, Plan provisions and federal law.

Except when federal law requires the plan to be the primary payor, the benefits under this Plan for Members entitled to Medicare Part A or enrolled in Medicare Part B, do not duplicate any benefit to which Members are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the plan, to the extent the plan has made payment for such services.

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.

Notice

We will meet any notice requirements by mailing the notice to You at the address listed in Our records. You may review Your EOC online at www.anthem.com/ca or request a hard copy be mailed to You.

You will meet any notice requirements by mailing the notice to:

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

Terms of Coverage

- In order for You to be entitled to benefits under this Agreement on a specific date, Your coverage under this Agreement must be in effect on the date You received services or supplies except as specifically stated in “Continuation of Care After Termination of a Provider” this section.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by Us as provided in “Right to Change Agreement” below.
- 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.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not 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 1-855-634-3381 for a copy of Our policies and procedures for preserving Your medical record confidentiality.

Third Party Liability

These provisions apply when We pay benefits as a result of injuries or illness You sustained and You have a right to a recovery or have received a recovery as a result of actions or omissions of a third party. We will automatically have a lien upon any recovery. Our lien will equal the amount of benefits We pay on Your behalf for injuries, disease, condition or loss You sustained as a result of any act or omission for which a third party is liable. Our lien will not exceed the amount We actually paid for those services. 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 this section, "recovery" means money You (or Your estate, parent, trustee or legal guardian) receive, are entitled to receive, or have a right to receive, whether by judgment, award, settlement or otherwise as a result of injury or illness caused by the third party, regardless of whether liability is contested. In this section "third party" refers to any person or entity who is legally responsible in relation to the injuries or illnesses sustained by You for which We paid benefits, including but not limited to the party(ies) who caused the injury or illness ("tortfeasor"), the tortfeasor's insurer, the tortfeasor's indemnifier, the tortfeasor's guarantor, the tortfeasor's principal or any other person or entity responsible or liable for the tortfeasor's acts or omissions, Your own insurer (underinsured or uninsured motorist benefits, medical payments, no fault benefits, personal injury protection, etc.), or any other person, entity, policy or plan that may be liable or responsible in relation to the injuries or illness, to the extent permitted by law.

Subrogation and Right of Reimbursement

- We will be entitled to collect on the full amount of Our lien, except that Our recovery is limited to the lesser of:
    - the total lien minus a pro rata reduction for reasonable attorney fees and costs; or
    - one-third of the moneys due to the enrollee or insured under any final judgment, compromise or settlement agreement if You have an attorney; or
    - one-half of the moneys due to the enrollee or insured under any final judgment, compromise, or settlement agreement if You do not have an attorney.
    - If 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.
- We, or Our designee, have first priority for the full amount of Our lien and shall be entitled to payment, reimbursement and/or subrogation to the extent of the total amount of Our lien regardless of whether the total amount of the recovery on account of the injury or illness is less than the actual loss suffered by You (or Your estate, parent, trustee or legal guardian).
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.
- If You fail to repay Us, fail to cooperate or Our lien is otherwise not recovered by Us, We shall be entitled to deduct any of the unsatisfied portion of Our lien or the amount of Your recovery, whichever is less, from any future benefit under the Plan.
- In the event that You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of Our lien or the amount of Your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.

Member's Duties

- Your signed application for coverage and/or Your receipt of benefits under this Plan authorizes and/or acknowledges each of Our rights set forth in this section.
- You, or Your attorney, must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties involved.
- You agree to advise Us, directly or through Your attorney, in writing of Your claim against a third party, or a claim against Your own insurance, within sixty (60) days of making such claim, unless a shorter period of time is prescribed by law, and that You or Your attorney will take such action,

furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our lien rights.

- Relevant information includes, but is not limited to, police reports, pleadings, settlement agreements, and communications with any party regarding the accident, incident, injury or illness.
- Neither You, nor Your attorney, shall take any action that may prejudice Our rights or interests under this section.
- You and/or Your attorney must cooperate with Us in the investigation, settlement and protection of Our rights.
- You and/or Your attorney must immediately notify Us if a trial is commenced, if a settlement occurs or is consummated, or if potentially dispositive motions are filed in a case.
- You and/or Your attorney must hold in trust the extent of Our lien that is recoverable by Us under the law and the Recovery must not be dissipated or disbursed until such time as We have been repaid in accordance with these provisions.
- If You, or Your attorney, fail to give Us notice, fail to cooperate with Us, or intentionally take any action that prejudices Our rights, You will be in 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.

Nothing in this Plan shall be construed to limit Our right to utilize any remedy provided by law to enforce Our rights to recover Our lien.

The plan is entitled to recover any attorney's fees and costs incurred in enforcing any provision in this section.

Severability

In the event that any provision in this Agreement is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Agreement will remain in force and effect.

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Right to Change 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.

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)," this Agreement does not cover any condition for which benefits are covered by any worker's compensation law or similar law.

Care Coordination

We pay In Network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay In Network Providers a separate amount for each Covered Service they provide. We may also pay them one (1) amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay In Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In Network Providers for coordination of Member care. In some instances, In Network

Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by In Network Providers to Us under these programs.

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 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.

Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Value-Added 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). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

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 Plan 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.

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 or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

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 receive;
    - 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 effect 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 do not understand any type of care You are 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 Your coverage with Us.
- inform Member Services 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 Member Services number on Your ID Card.

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 Your Evidence of Coverage or Your "Schedule of Cost Share and Benefits" and not by this Member Rights and Responsibilities statement.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Agreement so they are easy to identify.

Advance Payments of the Premium Tax Credit (APTC)

Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Agreement

This Anthem Individual EPO Evidence of Coverage and Disclosure Form issued to You by Anthem.

Ambulatory Surgical Center

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.

American Indian

An individual who is a member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Anthem Blue Cross ("Anthem")

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.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the "If You Have a Complaint or an Appeal" section of this Agreement.

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 doctor, or requires special services or Facilities not available at a contracting Hospital, but only when the Referral has been authorized ***before*** services are rendered and when the following conditions are met:

- there is no In Network doctor who practices in the appropriate specialty, or
- there is no contracting Hospital which provides the required services or has the necessary Facilities that meet the adequacy and accessibility requirements of State or federal law, and
- the Member is referred to Hospital or doctor that does not have an agreement with Anthem for a Covered Service by an Anthem In Network doctor

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 Reasonable and Customary Value and the Out of Network Provider's charge. See Your "Schedule of Cost Share and Benefits" and "How Your Claims are Paid" for more details.

Benefit Period/Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a calendar Year for this Plan, as listed in the "Schedule of Cost Share and Benefits." If Your coverage ends earlier, the Benefit Period/Year ends at the same time.

Brand Drugs (Brand Name Drugs)

Prescription Drugs that We classify as Brand Name Drugs or Our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

Compounded (Combination) Medications (Compound Drugs)

When all the active ingredients of the Compound Drug are FDA-approved in the form in which they are used in the Compound Drug, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.

Controlled Substances

Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

Cost Share (Cost Sharing)

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

Covered Services

Services, supplies or treatments which are:

- medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section;
- within the scope of the Provider's license;
- rendered while coverage under this Agreement is in force;
- not Experimental or Investigational or not covered by this Agreement; and
- authorized in advance if such preauthorization is required in this Agreement.

Deductible

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Cost Share and Benefits".

Dependent

A member of the Subscriber's family who meets the rules listed in the "When Membership Changes (Eligibility)" section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In Network Pharmacy that has executed a Designated Pharmacy Provider agreement with Us or an In Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Effective Date

The date when a Member's coverage begins under this Agreement.

Emergency Medical Condition (Emergency)

A medical or behavioral health 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 (1) of the following conditions:

- placing the health of the individual or another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

- a medical or behavioral health 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
- within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

The term "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.

Exchange

The Health Benefit Exchange of California also known as Covered California.

Experimental and Experimental Procedures

Those procedures 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

A Facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Center, chemical dependency treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or Mental Health Facility, as defined in this Agreement. The Facility must be licensed, accredited, registered and approved by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

Gender Identity Disorder (Gender Dysphoria) (GID)

A formal diagnosis used by psychologists and doctors 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

The process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Generic/Generic Drugs

Prescription Drugs that We classify as Generic Drugs or that Our 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.

Habilitative Services

Health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not 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.

Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Drugs) through a mail order service.

Home Health Care Agency

An entity, licensed in the state in which it is located, which:

- provides skilled nursing and other services on a visiting basis in the Member's home; and
- is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending doctor.

Hospital

A health Facility which provides diagnosis, treatment and care of persons who need acute Inpatient Hospital care under the supervision of doctors, 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 by California law. 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 doctor as medical director; and
- actually providing an acute level of care.

Identification Card/ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In Network Pharmacy

An In Network Pharmacy is a Pharmacy that has an In Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In Network Pharmacies may be based on a restricted network, and may be different than the network of In Network Pharmacies for Our other products. To find an In Network Pharmacy near You, call Pharmacy Member Services at the telephone number on the back of Your Identification Card.

In Network Provider

A Provider that has a contract, either directly or indirectly, with Us, or another organization, to give Covered Services to Members through negotiated payment arrangements under this Plan.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than twenty-four (24) hours.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three (3) hours per day, three (3) days per week.

Investigational and Investigational Procedures

Those procedures 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

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 Pharmacy Member Services at 1-833-236-6196 or check Our web site at www.anthem.com/ca for more details.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the “How Your Claims are Paid” section.

Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medical Emergency

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 be expected to result in:

- permanently placing the Member’s health in jeopardy;
- causing other serious medical or psychiatric consequences;
- causing serious impairment to bodily functions;
- causing serious and permanent dysfunction of any bodily organ or part;
- rendering the patient an immediate danger to himself or herself or others; or
- immediately unable to provide for, or utilize food, shelter or clothing due to the mental disorder.

Medically Necessary and Medical Necessity Services

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;
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Member's illness, injury or disease;
- not primarily for the convenience of the Member, doctor or other health care Provider; and
- not more costly than an alternative service, including the same service in an alternative setting, 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 example, We will not provide coverage for an Inpatient admission for a surgery if the surgery could have been performed on an Outpatient basis, or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting.

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 doctors, 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.

Medically Necessary Orthodontic Care

A service for pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Medically Necessary Orthodontic Care to be covered. See the "Medically Necessary Orthodontic Care" benefit description in the "Child Dental Care" section for more information.

Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a Mental Health or Substance Abuse (also known as chemical dependency) condition. Mental Health includes Severe Mental Illness and Serious Emotional Disturbances of a Child no matter what the cause. 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 and bulimia nervosa. Serious Emotional Disturbances of a Child is the presence of one 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 use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norm. The child must also meet one (1) or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two (2) of the following areas:
    a. self-care
    b. school functioning
    c. family relationships

   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
   c. risk of violence
3. The child meets special education eligibility requirements under Government Code.

Mental Health also includes mental or nervous identified as a “mental disorder” in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM IV).

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: 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 benefits risk pool, or as the Secretary of HHS recognizes.

Other Eligible Providers

Providers who do not enter into agreements with Us. These Providers include:

- blood bank
- dentist (D.D.S.)
- dispensing optician

Other Practitioners

Practitioners that include nurse practitioners, certified nurse midwives, physical therapists, occupational therapists, respiratory therapists, speech and language therapists, licensed clinical social workers, 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

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.

Out of Network Provider

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. There are no benefits provided when using an Out of Network Provider and You may be responsible for the total amount billed by an Out of Network Provider. Services received from an Out of Network Provider as a result of a Medical Emergency, Urgent Care or an Authorized Referral are exceptions. Also, if You receive Covered Services at an In Network Facility at which, or as a result of which, You receive services provided by an Out of Network Provider, You will pay no more than the same Cost Sharing that You would pay for the same Covered Services received from an In Network Provider.

Out of Pocket Maximum

The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out of Pocket Maximum does not include Your Premium, amounts over the Maximum Allowed Amount, or charges for health care that Your Plan does not cover. When the Out of Pocket Maximum is reached, no additional Deductible, Copayment or Coinsurance is required unless otherwise specified in this Agreement. Please see the “Schedule of Cost Share and Benefits” for details.

Outpatient

A Member who receives services or supplies when not an Inpatient.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six (6) hours per day, five (5) days per week.

Pharmacy

A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a Prescription from Your doctor.

Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines within Your benefit program. The process includes health care professionals such as nurses, pharmacists, and doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Prescription Drug List. Our programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

Anthem's PBM, 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.

Plan

The set of benefits, conditions, exclusions and limitations described in this document.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay Anthem to establish and maintain coverage under this Agreement.

Prescription Drug (also referred to as Legend Drug)

A medicine that is approved by the FDA to treat illness or injury. Under the Federal Food, Drug and 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 all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products With Therapeutic Equivalence Evaluations*, require a Prescription to dispense and are not essentially the same as an FDA-approved product from a drug manufacturer
2. insulin, diabetic supplies, and syringes

Prescription Drug List

Listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as covered drugs. The list of approved Prescription Drugs developed by Anthem in consultation with doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List 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 Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request and at www.anthem.com/ca.

Prescription Order (Prescription)

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (PCP)

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Us. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider

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 Member Services at 1-855-634-3381.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

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

Qualified Health Plan or QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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.

Rehabilitative Services

Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center

A Provider licensed and operated as required by law, which includes:

1. room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight (8) hours daily with twenty-four (24) hour availability
2. a staff with one (1) or more doctors available at all times
3. residential treatment takes place in a structured Facility-based setting
4. the resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder
5. Facilities are designated residential, sub-acute or intermediate care and may occur in care systems that provide multiple levels of care
6. is fully accredited by Joint Commission on Accreditation of Healthcare Organizations (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term Residential Treatment Center does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized health care professional's order.

Self-Administered Drugs

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)) (SED)

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 the Education Code and is determined to have an emotional disturbance as defined in the Code of Federal Regulations.

Service Area

The geographic area within the State of California within which this Agreement is offered and issued.

Severe Mental Illness (SMI)

This 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).

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for You after a Hospital stay when You have a condition that needs more care than You can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by Us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury
2. care supervised by a doctor
3. twenty-four (24) hour per day nursing care supervised by a full-time registered nurse

A Skilled Nursing Facility is not a place mainly for care of the aged, custodial care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician or SCP)

A doctor 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 doctors 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

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 PBM's Specialty Pharmacy unless stated otherwise. Specialty Drugs may be placed on drug tiers 1, 2, 3 or 4.

Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy of Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

The State of California.

Subscriber

The Member who applied for coverage and in whose name this Agreement is issued.

Tax Dependent

Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. to file an income tax return for the Benefit Year;
2. if married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. that no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Year; and
4. that he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse or domestic partner.

Urgent Care

Medical care for an unexpected illness or injury that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

Utilization Review

Evaluation of the necessity, quality, effectiveness or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures and/or Facilities.

We, Us and Our

Anthem Blue Cross (Anthem).

Year and Yearly

A twelve (12) month period.

You and Your

The Member, Subscriber and each covered Dependent.

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.