GROUP BLANKET POLICY

for

RANCHO SANTIAGO CCD

(Note: This *policy* was issued to the *group* pursuant to its association with
the Student Accident Insurance Network ("S.A.I.N.") program.)
(the *group*)

ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (Anthem Blue Cross Life and Health) agrees to provide the benefits of this *policy* for *insured persons* of the *group*. These benefits are subject to all of the terms and conditions of this *policy*.

POLICY EFFECTIVE DATE ....August 1, 2024

To the extent not preempted by federal law or regulation, this *policy* will be governed, interpreted and enforced to remain in compliance with the laws of the state of California, along with applicable federal statutes and regulations. Nothing contained in this *policy* will be construed as Anthem Blue Cross Life and Health doing business in any state or jurisdiction in which it is not duly authorized.

This *policy* has been approved by the officers of Anthem Blue Cross Life and Health Insurance Company to become effective at 6:01 Pacific Standard Time on the Policy Effective Date shown above. Payment of the annual premium indicates the *group's* acceptance of this *policy*.

The change in Policy Effective Date from the preceding *policy* indicates a change in terms and provisions and is thus a modification and continuation of the *policy* between Anthem Blue Cross Life and Health and the *group* to provide group benefits.

Beth P. Andersen
President

Kathy Kiefer
Corporate Secretary

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The *italicized* terms appearing in this *policy* are defined in the DEFINITIONS.

GENERAL PROVISIONS

POLICY COMPONENTS

The entire *policy* consists of:

1. these pages, including any endorsements; and
2. the application of the group.

This *policy* does not include the charter or by-laws of Anthem Blue Cross Life and Health.

LIABILITY FOR STATEMENTS

No statement made by the *group* or any *insured person*, unless it appears on the written application or is fraudulent, will be used in any contest of the coverage under this *policy*. Statements made by the *group* shall not be deemed warranties. After the *policy* has been in force for 24 months, no statement will be used in any contest of coverage under this *policy*.

PARTICIPATION REQUIREMENTS

All of the persons eligible to be *insured persons* under this *policy* must be reported for coverage. If the number of *insured persons* covered falls below 50, Anthem Blue Cross Life and Health may cancel this *policy*.

POLICY CHANGES

No agent of Anthem Blue Cross Life and Health may change this *policy* or waive any of its contents. Anthem Blue Cross Life and Health and the *group* may change the provisions of this *policy* at any time by mutual consent. Anthem Blue Cross Life and Health may also change this *policy* as provided in 2 below.

No change in this *policy* is valid unless the change is made in one of the following ways:

1. In the case of a written request by the *group* for a change, by an endorsement that is signed by the officers of Anthem Blue Cross Life and Health.
2. In the case of a change required by Anthem Blue Cross Life and Health, by an endorsement that is: (a) signed by the officers of Anthem Blue Cross Life and Health; and (b) effective no less than 60 days after written notice from Anthem Blue Cross Life and Health of its intent to make such a change.

CLERICAL ERRORS

1. Clerical errors made by the *group* do not deprive any *insured person* of his or her coverage under this *policy*.
2. Clerical errors made by the *group* will not continue any *insured person's* coverage which would not otherwise be effective.
3. Any premium rate adjustment due to the correction of a clerical error will be made on the next Premium Due Date after the facts are made known to Anthem Blue Cross Life and Health. Adjustments for retroactive changes are made in accordance with the "Accuracy of Information" provision of the section entitled PREMIUM PROVISIONS.

POLICY EFFECTIVE DATE

The Policy Effective Date is the date the *policy* between Anthem Blue Cross Life and Health and the *group* becomes effective. This date and any other date in this *policy* begins at 6:01 a.m. Pacific Standard Time.

GENERAL PROVISIONS

MAILING ADDRESSES

Any notice required of Anthem Blue Cross Life and Health in this *policy* will be mailed to the address of the *group* as shown on Anthem Blue Cross Life and Health records. Any notice required of the *group* in this *policy* must be mailed to Anthem Blue Cross Life and Health Insurance Company at P.O. Box 70000, Van Nuys, California 91470.

GROUP RECORDS

The *group* is responsible for keeping records relating to this *policy*. Anthem Blue Cross Life and Health has the right to inspect and audit those records. In the event of the termination of this *policy*, Anthem Blue Cross Life and Health maintains the right to inspect those records pertinent to the period of time this *policy* was in effect.

CANCELLATION

Either Anthem Blue Cross Life and Health or the *group* may cancel this *policy* by giving at least 31 days prior written notice to the other party. The notice will state when the cancellation will take effect. If no written notice is given, the *policy* renews on the same terms and conditions.

In the event of cancellation, by either Anthem Blue Cross Life and Health or the *group,* Anthem Blue Cross Life and Health will promptly return, on a pro rata basis, the unearned premium paid, if any; and, the *group* must promptly pay, on a pro rata basis, any premium Anthem Blue Cross Life and Health has earned which has not been paid. Cancellation will no affect any claim that starts before the effective date of cancellation.

OUT OF AREA SERVICES

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

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

Under the BlueCard® Program, when an *insured person* accesses covered healthcare services within the geographic area served by a Host Blue, Anthem Blue Cross Life and Health will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever an *insured person* accesses covered healthcare services outside Anthem Blue Cross Life and Health’s service area and the claim is processed through the BlueCard® Program, the amount an *insured person* pays for covered healthcare services is calculated based on the lower of:

- The billed covered charges for the covered services; or
- The negotiated price that the Host Blue makes available to Anthem Blue Cross Life and Health.

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

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

Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, Anthem Blue Cross Life and Health would then calculate an *insured person’s* liability for any covered healthcare services according to applicable law.

Providers available to an *insured person* through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If an *insured person* has any questions or complaints about the BlueCard Program, please call customer service.

PROVIDING OF CARE

Anthem Blue Cross Life and Health is not responsible for providing any type of *hospital*, medical or similar care. Also, Anthem Blue Cross Life and Health is not responsible for the quality of any type of *hospital*, medical or similar care received.

INDEPENDENT CONTRACTORS

The relationship between Anthem Blue Cross Life and Health and providers is that of an independent contractor. *Physicians*, and *other health care professionals*, *hospitals*, *skilled nursing facilities* and other community agencies are not agents of Anthem Blue Cross Life and Health nor is Anthem Blue Cross Life and Health, or any employee of Anthem Blue Cross Life and Health, an employee or agent of any *hospital*, medical group or medical care provider of any type.

NON-REGULATION OF PROVIDERS

The benefits provided under this *plan* do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with *participating providers*.

TERMS OF COVERAGE

1. In order for an *insured person* to be entitled to benefits under the *policy*, both the *policy* and their coverage under the *policy* must be in effect on the date the expense giving rise to a claim for benefits is incurred.

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

3. The *policy* is subject to amendment, modification or termination according to the provisions of the *policy* without an *insured person’s* consent or concurrence.

GENERAL PROVISIONS

PROTECTION OF COVERAGE

Anthem Blue Cross Life and Health does not have the right to cancel an *insured person's* coverage under this *plan* while:

1. This *plan* is in effect;

2. They are eligible; and

3. Their premium charges are paid according to the terms of the *policy*.

FREE CHOICE OF PROVIDER

This *plan* in no way interferes with an *insured person's* right as an *insured person* entitled to *hospital* benefits to select a *hospital*. They may choose any *physician* who holds a valid *physician* and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the *hospital* where services are received. They may also choose any other health care professional or facility which provides care covered under this *plan*, and is properly licensed according to appropriate state and local laws. However, an *insured person's* choice may affect the benefits payable according to this *plan*.

MEDICAL NECESSITY

The benefits of this *plan* are provided only for services that are *medically necessary*. The services must be ordered by the attending *physician* for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this *plan* is available to the *insured person* upon request.

EXPENSE IN EXCESS OF BENEFITS

Anthem Blue Cross Life and Health is not liable for any expense the *insured person* incurs in excess of the benefits of this *plan*.

BENEFITS NOT TRANSFERABLE

Only the enrolled *insured person* is entitled to receive benefits under this *plan*. The right to benefits cannot be transferred.

NOTICE OF CLAIM

The *insured person*, or someone on their behalf, must give Anthem Blue Cross Life and Health written notice of a claim within 120 days after the *insured person* incurs covered charges under this plan, or as soon as reasonably possible thereafter.

PROOF OF LOSS

The *insured person* or the provider of service must send Anthem Blue Cross Life and Health properly and fully completed claim forms within 120 days of the date the *insured person* receives the service or supply for which a claim is made. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. Except in the absence of legal capacity, Anthem Blue Cross Life and Health is not liable for the benefits of the *plan* if the *insured person* does not file claims within the required time period. Anthem Blue Cross Life and Health will not be liable for benefits if they do not receive written proof of loss on time.

Services received and charges for the services must be itemized, and clearly and accurately described. Claim forms must be used; cancelled checks or receipts are not acceptable.

TIMELY PAYMENT OF CLAIMS

Any benefits due under this *plan* shall be due once Anthem Blue Cross Life and Health has received proper, written proof of loss, together with such reasonably necessary additional information they may require to determine their obligation.

PAYMENT TO PROVIDERS

Anthem Blue Cross Life and Health will pay the benefits of this *plan* directly to *contracting hospitals*, *participating providers* and medical transportation providers. Also, Anthem Blue Cross Life and Health will pay *non-contracting hospitals* and other providers of service directly when the *insured person* assigns benefits in writing. If the *insured person* is a MediCal beneficiary and they assign benefits in writing to the State Department of Health Services, Anthem Blue Cross Life and Health will pay the benefits of this *plan* to the State Department of Health Services. These payments will fulfill Anthem Blue Cross Life and Health's obligation to the *insured person* for those covered services.

RIGHT OF RECOVERY

Whenever payment has been made in error, Anthem Blue Cross Life and Health will have the right to recover such payment from an *insured person* or, if applicable, the provider, in accordance with applicable laws and regulations. In the event Anthem Blue Cross Life and Health recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, Anthem Blue Cross Life and Health will only recover such payment from the provider within 365 days of the date they made the payment on a claim submitted by the provider. Anthem Blue Cross Life and Health reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if Anthem Blue Cross Life and Health pays an *insured person's* healthcare provider amounts that are the *insured person's* responsibility, such as deductibles, co-payments or co-insurance, Anthem Blue Cross Life and Health may collect such amounts directly from the *insured person*. The *insured person* agrees that Anthem Blue Cross Life and Health has the right to recover such amounts from the *insured person*.

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

Anthem Blue Cross Life and Health has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. Anthem Blue Cross Life and Health will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem Blue Cross Life and Health may not provide the *insured person* with notice of overpayments made by them or the *insured person* if the recovery method makes providing such notice administratively burdensome.

WORKER'S COMPENSATION INSURANCE

The *policy* does not affect any requirement for coverage by worker's compensation insurance. It also does not replace that insurance.

GENERAL PROVISIONS

PHYSICAL EXAMINATION

At their expense, Anthem Blue Cross Life and Health has the right and opportunity to examine any *insured person* claiming benefits when and as often as reasonably necessary while a claim is pending.

LEGAL ACTIONS

No attempt to recover on the plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

CONFORMITY WITH LAWS

Any provision of the *policy* which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

PREMIUM PROVISIONS

PAYMENT DATES

The *group* will pay Anthem Blue Cross Life and Health premium listed in the PREMIUM RATE SCHEDULE. The first payment is due on or before the Policy Effective Date. This *policy* remains in effect for the Policy Term shown in the Premium Rate Schedule. Succeeding premiums are due on the first day of each following Policy Term. This day is the Premium Due Date. In lieu of premium payment as indicated above, the *group* and Anthem Blue Cross Life and Health may agree on some other premium payment arrangement that produces the same result.

CHANGE OF PREMIUM RATE

Premium rates may be changed by Anthem Blue Cross Life and Health as of any Premium Due Date, but, not prior to the first anniversary of the Policy Effective Date unless indicated in the Premium Rate Schedule. Anthem Blue Cross Life and Health must send written notice of any change in premium rates at least 60 days before the date the change goes into effect.

ACCURACY OF INFORMATION

Responsibilities of the Group. The *group* is responsible for supplying up-to-date eligibility information. Anthem Blue Cross Life and Health may rely upon the latest information received as correct without verification; however, Anthem Blue Cross Life and Health maintains the right to verify any eligibility information provided by the *group*.

PREMIUM RATE SCHEDULE

Annual premium rates. The *group* will pay to Anthem Blue Cross Life and Health the following total annual premium rate.

Total Annual Premium Rate $125,296.00

Policy Term. The initial Policy Term will be from the Policy Effective Date through the expiration August 1, 2025. Subsequent Policy Terms will be August 1 through July 31, of each year, respectively.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

CLASSES OF PERSONS INSURED

- *Students* -
  - while attending regularly scheduled classes at college; or
  - while attending college-sponsored activities, including *club activities*, or traveling under college supervision to and from college sponsored events.

- *Student* Athletes -
  - while participating in or attending any regularly scheduled practice or competition supervised by an authorized representative of the college; or
  - while traveling directly to and from practice or competition with other members as a group, provided such travel is supervised by an authorized representative of the college.

- *Child*(ren) of *Students* -
  - while in or about the child care facility provided by the college, provided that the facility is on the college campus; or
  - while attending "Mommy and me" classes provided by the college with their *student* parent, if applicable.

- High Risk *Students* -
  - *students* who have paid the appropriate premiums, attending Fire or Police Academies associated with the college.

DEDUCTIBLES

Per Accident Deductibles

The deductible is determined by the nature of the *insured person's* activities at the time of the accident, as follows.

- *Student Activities* Deductible .... **None**
- *Class 1 Athletic Activities* Deductible .... **None**
- *Class 2 Athletic Activities* Deductible .... **None**
- *Child of Student in Child Care Facility Activities* Deductible .... **None**

Note: No deductible applies to Emergency Illness.

PAYMENT RATE

After the Per Accident Deductible has been satisfied, we will pay the following percentages of the *maximum allowed amount*.

- Participating Providers 100%
- All other Providers 50%*

*But, it will be 100% for the *maximum allowed amount* incurred: (a) in SKILLED NURSING FACILITIES, and (b) for EMERGENCY SERVICES (**for the first 48 hours only**, unless, the *insured person* cannot be safely moved).

SCHEDULE OF BENEFITS

MEDICAL BENEFIT MAXIMUMS

We will pay, for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered *skilled nursing facility* care .... **100 days** per accident

Home Health Care

- For covered home health services .... **100 visits** per accident

Prosthetic Devices

- For covered supplies and services .... **$1,000** per accident

Durable Medical Equipment

- For covered charges for rental or purchase .... **$2,000** per accident

Physical Therapy, Physical Medicine and Occupational Therapy

- For covered outpatient services .... **24** visits per accident

- For each covered visit when provided by a *non-participating provider* .... **$25** per visit

Dental Injury

- For all covered services .... **$2,000** per accident

Acupuncture

- For all covered services .... **$25** per visit, for up to 12 visits per accident

SCHEDULE OF BENEFITS

Maximum per Accident

The maximum is determined by the nature of the *insured person's* activities at the time of the accident. (See Deductible above .)

- *Student Activities* Maximum **$50,000**
  per accident
- *Class 1 Athletic Activities* Maximum **$25,000**
  per accident
- *Class 2 Athletic Activities* Maximum **$25,000**
  per accident
- *Child of Student in Child Care Facility Activities* Maximum **$50,000**
  per accident

Maximum per Emergency Illness

- For all covered services.. **$500**
  for all emergency illness per semester

General

This section describes the term "*maximum allowed amount"* as used in this *plan*, and what the term means to the *insured person* when obtaining covered services under this *plan*. The *maximum allowed amount* is the total reimbursement payable under the *insured person's* plan for covered services he or she receives from *participating* and *non-participating providers*. It is our payment towards the services billed by the *insured person's* provider combined with any Deductible or Co-Payment owed by the *insured person*. In some cases, the *insured person* may be required to pay the entire *maximum allowed amount*. For instance, if the *insured person* has not met his or her Deductible under this *plan*, then the *insured person* could be responsible for paying the entire *maximum allowed amount* for covered services. In addition, if these services are received from a *non-participating provider*, the *insured person* may be billed by the provider for the difference between their charges and our *maximum allowed amount*. In many situations, this difference could be significant.

We have provided two examples below, which illustrate how the *maximum allowed amount* works. These examples are for illustration purposes only.

Example: The plan has an *insured person* Co-Payment of 30% for *participating provider* services after the Deductible has been met.

- The *insured person* receives services from a *participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *insured person's* Co-Payment responsibility when a *participating* surgeon is used is 30% of $1,000, or $300. This is what the *insured person* pays. We pay 70% of $1,000, or $700. The *participating* surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has an *insured person* Co-Payment of 50% for *non-participating provider* services after the Deductible has been met.

- The *insured person* receives services from a *non-participating* surgeon. The charge is $2,000. The *maximum allowed amount* under the plan for the surgery is $1,000. The *insured person's* Co-Payment responsibility when a *non-participating* surgeon is used is 50% of $1,000, or $500. We pay the remaining 50% of $1,000, or $500. In addition, the *non-participating* surgeon could bill the *insured person* the difference between $2,000 and $1,000. So the *insured person's* total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

When the *insured person* receives covered services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the *maximum allowed amount* if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if the *insured person's* provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the *maximum allowed amount* will be based on the single procedure code.

Provider Network Status

The *maximum allowed amount* may vary depending upon whether the provider is a *participating provider,* a *non-participating provider* or *other health care provider*.

Participating Providers. For covered services performed by a *participating provider* the *maximum allowed amount* for this *plan* will be the rate the *participating provider* has agreed with us to accept as reimbursement for the covered services. Because *participating providers* have agreed to accept the *maximum allowed amount* as payment in full for those covered services, they should not send the *insured person* a bill or collect for amounts above the *maximum allowed amount.* However, the *insured person* may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent he or she has not met his or her Deductible or have a Co-Payment. Please call customer service for help in finding a *participating provider* or visit www.anthem.com/ca.

If the *insured person* goes to a *hospital* which is a *participating provider*, the *insured person* should not assume all providers in that *hospital* are also *participating providers*. To receive the greater benefits afforded when covered services are provided by a *participating provider,* the *insured person* should request that all his or her provider services (such as services by an anesthesiologist) be performed by *participating providers* whenever he or she enter a *hospital*.

If the *insured person* is planning to have outpatient surgery, the *insured person* should first find out if the facility where the surgery is to be performed is an *ambulatory surgical center.* An *ambulatory surgical center* is licensed as a separate facility even though it may be located on the same grounds as a *hospital* (although this is not always the case). If the center is licensed separately, the *insured person* should find out if the facility is a *participating provider* before undergoing the surgery.

Non-Participating Providers and Other Health Care Providers.

Providers who are not in our Prudent Buyer network are *non-participating providers* or *other health care providers,* subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services the *insured person* receives from a *non-participating provider* or *other health care provider* the *maximum allowed amount* will be based on the applicable Anthem Blue Cross Life and Health *non-participating provider* rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the *non-participating provider,* an amount derived from the total charges billed by the *non-participating provider,* an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, Anthem Blue Cross Life and Health will update such information, which is unadjusted for geographic locality, no less than annually.

Unlike *participating providers*, *non-participating providers* and *other health care providers* may send the *insured person* a bill and collect for the amount of the *non-participating provider's* or *other health care provider's* charge that exceeds our *maximum allowed amount* under this plan. The *insured person* may be responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating provider* or *other health care provider* charges. This amount can be significant. Choosing a *participating provider* will likely result in lower out of pocket costs to the *insured person*. Please call customer service for help in finding a *participating provider* or visit our website at www.anthem.com/ca. Customer service is also available to assist the *insured person* in determining this *plan's maximum allowed amount* for a particular *covered service* from a *non-participating provider* or *other health care provider.*

The *insured person* will always be responsible for expense incurred which is not covered under this *plan*.

Cost Share

For certain covered services, and depending on the *insured person's* plan design, the *insured person* may be required to pay all or a part of the *maximum allowed amount* as his or her cost share amount (Deductibles or Co-Payments). The *insured person's* cost share amount and the Out-Of-Pocket Amounts may be different depending on whether the *insured person* received covered services from a *participating provider* or *non-participating provider*. Specifically, the *insured person* may be required to pay higher cost-sharing amounts or may have limits on his or her benefits when using *non-participating providers*. Please see the SUMMARY OF BENEFITS section for the *insured person's* cost share responsibilities and limitations, or call customer service to learn how this *plan's* benefits or cost share amount may vary by the type of provider the *insured person* uses.

Anthem Blue Cross Life and Health will not provide any reimbursement for non-covered services. The *insured person* may be responsible for the total amount billed by his or her provider for non-covered services, regardless of whether such services are performed by a *participating provider* or *non-participating provider*. Non-covered services include services specifically excluded from coverage by the terms of the *insured person's* plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances the *insured person* may only be asked to pay the lower *participating provider* cost share percentage when he or she use a *non-participating provider*. For example, if the *insured person* goes to a *participating* hospital or facility and receive covered services from a *non-participating provider* such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, the *insured person* will pay the *participating provider* cost share percentage of the *maximum allowed amount* for those covered services. However, the *insured person* also may be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge.

Authorized Referrals

In some circumstances we may authorize *participating provider* cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service the *insured person* receives from a *non-participating provider*. In such circumstance, the *insured person* or his or her *physician* must contact us in advance of obtaining the covered service. It is the *insured person's* responsibility to ensure that we have been contacted. If we authorize a *participating provider* cost share amount to apply to a covered service received from a *non-participating provider*, the *insured person* also may still be liable for the difference between the *maximum allowed amount* and the *non-participating provider's* charge. Please call customer service for *authorized referral* information or to request authorization.

MEDICAL BENEFITS

MEDICAL DEDUCTIBLES AND BENEFIT MAXIMUMS

After we subtract any applicable deductible from the *maximum allowed amount*, we will pay benefits at the Payment Rate which applies to such expense, up to the applicable Medical Benefit Maximums. The Deductible amounts, Payment Rates and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this *plan* is separate and distinct from the other. Only the covered charges that make up the *maximum allowed amount* will apply toward satisfaction of any deductible. No deductible applies to *emergency illness*.

Per Accident Deductible. Each time an *insured person* has an *accidental injury*, they will be responsible for satisfying the Per Accident Deductible before we begin to pay benefits.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any *insured person* in excess of any of the Medical Benefit Maximums. The Per Accident Maximum and Emergency Illness Maximum under this *plan* will be reduced by any benefits paid by Anthem Blue Cross Life and Health to the *insured person* or on their behalf under any other similar health plan provided by Anthem Blue Cross Life and Health and sponsored by the *group*.

MEDICAL BENEFITS

CONDITIONS OF COVERAGE

This *policy* only covers losses resulting from *accidental injuries* and *emergency illness.* The following conditions of coverage must be met for expense incurred for services or supplies to be covered under this plan.

1. The *accidental injury* or *emergency illness* causing the expense must occur while the *insured person* is covered under this plan.

2. a. In connection with an *accidental injury*:

   – the first expense the *insured person* incurs for the treatment of the injury must be incurred within one hundred twenty days of the date of the injury; and

   – all other expense they incur for the treatment of the injury must be incurred within one year of the date of the injury.

   b. In connection with an *emergency illness*, the *insured person* must incur this expense prior to the end of the semester in which the illness commences.

   Expense is incurred on the date the *insured person* receives the service or supply for which the charge is made.

3. The expense must be for a medical service or supply furnished to an *insured person* as a result of *emergency illness* or *accidental injury*, unless a specific exception is made.

4. The expense must be for a medical service or supply included in MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SCHEDULE OF BENEFITS.

5. The expense must not be for a medical service or supply listed in MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered covered under this plan.

6. The expense must not exceed any of the maximum benefits or limitations of this *plan*.

7. Any services received must be those which are regularly provided and billed by the *provider*. In addition, those services must be consistent with the illness, injury, degree of disability and the *insured person's* medical needs. Benefits are provided only for the number of days required to treat the *insured person's* illness or injury.

8. All services and supplies must be ordered by a *physician*.

Subject to the Medical Benefit Maximums in the SCHEDULE OF BENEFITS, the requirements set forth under MEDICAL BENEFITS: CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL BENEFITS: MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a *hospital*. The *maximum allowed amount* will not include charges in excess of the *hospital's* prevailing two-bed room rate unless there is a negotiated per diem rate between Anthem Blue Cross Life and Health and the *hospital*, or unless the *insured person's physician* orders, and Anthem Blue Cross Life and Health authorizes, a private room as *medically necessary*.

2. Services in *special care units*.

3. Outpatient services and supplies provided by a *hospital*, including outpatient surgery.

Hospital services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Skilled Nursing Facility. Inpatient services and supplies provided by a *skilled nursing facility*, for up to 100 days per accident. The amount by which the *insured person's* room charge exceeds the prevailing two-bed room rate of the *skilled nursing facility* is not considered covered under this plan.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Home Health Care. The following services provided by a *home health agency*:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a *physician*.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a *home health agency*. Services must be ordered and supervised by a registered nurse employed by the *home health agency* as professional coordinator. These services are covered only if the *insured person* is also receiving the services listed in 1 or 2 above.

5. *Medically necessary* supplies provided by the *home health agency*.

In no event will benefits exceed 100 visits per accident. One home health visit by a home health aide is defined as a period of covered service of up to four hours during any one day.

Home health care services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Ambulatory Surgical Center. Services and supplies provided by an *ambulatory surgical center* in connection with outpatient surgery.

Ambulatory surgical center services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Professional Services

1. Services of a *physician*.

2. Services of an anesthetist (M.D. or C.R.N.A.).

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport an *insured person* to and from a *hospital*.

2. Emergency services or transportation services that are provided to an *insured person* by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if the *insured person* believes they have an *emergency* medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company from the area where the *insured person* is first disabled to transport an *insured person* to the nearest *hospital* where appropriate treatment is provided if, and only if, such services are *medically necessary* and ground ambulance service is inadequate. Pre-service review is required for air ambulance in a non-medical *emergency*. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

4. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If the *insured person* has an emergency medical condition that requires an emergency response, please call the "911" emergency response system if the *insured person* is in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services.

Hemodialysis Treatment

Prosthetic Devices

1. Breast prostheses following a mastectomy.

2. *Prosthetic devices* to restore a method of speaking when required as a result of a covered *medically necessary* laryngectomy.

3. We will pay for other *medically necessary prosthetic devices,* limited to a maximum payment of **$1,000** per accident, including:

   a. Surgical implants;

   b. Artificial limbs or eyes; and

   c. The first pair of contact lenses or eye glasses when required as a result of a covered *medically necessary* eye surgery.

Durable Medical Equipment. Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

We will determine whether the item satisfies the conditions above. Our payment for rental or purchase will not exceed **$2,000** per accident.

Specific durable medical equipment is subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Blood. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Prescription Drugs and Medications. Drugs and medicines approved for general use by the Food and Drug Administration that are available only if prescribed by a *physician*. The drugs or medicine must be dispensed by a *physician* or a licensed pharmacist.

Dental Injury. Services of a *physician* (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an *accidental injury* to natural teeth. Coverage shall be limited to only such services that are *medically necessary* to repair the damage done by the *accidental injury* and/or restore function lost as a direct result of the *accidental injury*. Damage to natural teeth due to chewing or biting is not *accidental injury*.

Important: If the *insured person* decides to receive dental services that are not covered under this *plan*, a *participating provider* who is a dentist may charge the *insured person* his or her usual and customary rate for those services. Prior to providing the *insured person* with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If the *insured person* would like more information about the dental services that are covered under this *plan*, please call customer service. To fully understand the coverage under this *plan*, please carefully review this *policy*.

Physical Therapy, Physical Medicine and Occupational Therapy. The following services provided by a *physician* under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by injury including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a *physician* in that *physician's* office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

For the services of a *non-participating provider* only, our maximum payment is limited to **$25** for each visit.

Up to 24 visits per accident for all covered services are payable. But, if it is determined that an additional period of physical therapy, physical medicine or occupational therapy is *medically necessary*, we will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained, and remain limited to **$25** for each specified additional visit to a *non-participating provider*. (See UTILIZATION REVIEW PROGRAM.)

Outpatient Speech Therapy. Outpatient speech therapy following injury.

Acupuncture. The services of a *physician* for acupuncture treatment to treat an injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. We will pay for up to 12 visits per accident, and for up to a maximum of **$25** for all covered services rendered during each visit.

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this *plan* for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not *medically necessary*, as defined.

Experimental or Investigative. Any *experimental* or *investigative* procedure or medication. But, if the *insured person* is denied benefits because it is determined that the requested treatment is *experimental* or *investigative*, the *insured person* may request an independent medical review as described in INDEPENDENT MEDICAL REVIEW OF DENIALS OF EXPERIMENTAL OR INVESTIGATIVE TREATMENT.

Crime or Nuclear Energy. Conditions that result from: (1) the *insured person's* commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before the *insured person's effective date* or during an inpatient *stay* that began on or before their *effective date*. Services received after their coverage ends, but, this will not apply to:

1. an *accidental injury,* which occurred while covered, prior to the end of the one *year* period commencing on the date of the *accidental injury;* or

2. an *emergency illness,* which occurred while covered, prior to the end of the *semester* in which it occurs.

Excess Amounts. Any amounts in excess of the *maximum allowed amount,* the Maximum per Accident, or the Maximum per Emergency Illness.

Group Provided. Services rendered by any person employed or retained by the *group*.

"Club" Provided. Services received while attending or participating in a "club" sponsored event.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed *physician*, except as specifically provided or arranged by us.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the *insured person* does not claim those benefits.

Government Treatment. Any services actually given to the *insured person* by a local, state, or federal government agency, or by a public school system or school district, except when payment under this *plan* is expressly required by federal or state law. We will not cover payment for these services if the *insured person* is not required to pay for them or they are given to the *insured person* for free.

Services of Relatives. Professional services received from a person who lives in the *insured person's* home or who is related to them by blood or marriage.

Voluntary Payment. Services for which the *insured person* has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research *hospital*. Such a *hospital* must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;

2. At least **10%** of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the *hospital's* research.

Not Specifically Listed. Services not specifically listed in this *plan* as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the *insured person* and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

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

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specifically stated in the "Dental Injury" provision of MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests.

Hernia. Services and supplies in connection with a hernia of any kind, no matter how caused. Except elsewhere provided in this Policy.

Optometric Services or Supplies. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Orthopedic Supplies. Orthopedic shoes (except when joined to braces) or shoe inserts.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a *hospital stay* primarily for environmental change or physical therapy. *Custodial care* or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a *skilled nursing facility,* except as specifically stated in the "Skilled Nursing Facility" provision of MEDICAL CARE THAT IS COVERED.

Chronic Pain. Treatment of chronic pain.

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

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services, or nutritional counseling, except as specifically provided or arranged by us. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

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

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Physical Therapy or Physical Medicine. Services of a *physician* for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically stated in the "Home Health Care", or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Drugs and Medications. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, dietary supplements, health or beauty aids.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one’s lifestyle which may include but are not limited to diet, exercise, imagery or nutrition.

PRE-EXISTING CONDITION EXCLUSION

No payment will be made for services or supplies for the treatment of a *pre-existing condition* . This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to the *insured person's* coverage under this *plan*. Generally, this six-month period ends the day before the *insured person's* coverage becomes effective. However if the *insured person* were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy nor to a child who is enrolled in the *plan* within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to six months from the *insured person's* first day of coverage or, if the *insured person* was in a waiting period, from the first day of their waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, the *insured person* can reduce the length of this exclusion period by the number of days of their prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if the *insured person* has not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if the *insured person's* prior coverage was provided through an employer and ended because the *insured person's* employment (or the person's employment through whom the *insured person* had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section for a complete list of the types of coverage for which credit is given.

To reduce the six-month exclusion period by the *insured person's* *creditable coverage*, the *insured person* should give us a copy of any certificates of creditable coverage they have. There is no time limit within which the *insured person* must provide a certificate in order to receive credit for prior coverage. If the *insured person* does not have a certificate, but do have prior health coverage, we will help the *insured person* obtain one from their prior plan or carrier. There are also other ways that the *insured person* can show they have *creditable coverage*. Please contact Anthem Blue Cross Life and Health if the *insured person* needs help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service.

REIMBURSEMENT FOR ACTS OF THIRD PARTIES

Under some circumstances, the *insured person* may need services under this *plan* for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, we will provide the benefits of this *plan* subject to the following:

1. We will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that the *insured person* receives from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid by Anthem Blue Cross Life and Health under this *plan* for the treatment of the illness, disease, injury or condition for which the third party is liable.

   - If we paid the provider other than on a capitated basis, our lien will not be more than amount we paid for those services.

   - If the *insured person* hired an attorney to gain their recovery from the third party, our lien will not be for more than one-third of the money due the *insured person* under any final judgment, compromise, or settlement agreement.

   - If the *insured person* did not hire an attorney, our lien will not be for more than one-half of the money due the *insured person* under any final judgment, compromise or settlement agreement.

   - If a final judgment includes a special finding by a judge, jury, or arbitrator that the *insured person* was partially at fault, our lien will be reduced by the same comparative fault percentage by which the *insured person's* recovery was reduced.

   - Our lien is subject to a pro rata reduction equal to the *insured person's* reasonable attorney's fees and costs in line with the common fund doctrine.

2. The *insured person* must advise Anthem Blue Cross Life and Health in writing, within 60 days of filing a claim against the third party and take necessary action, furnish such information and assistance, and execute such papers as Anthem Blue Cross Life and Health may require to facilitate enforcement of its rights. They must not take action which may prejudice the rights or interest of Anthem Blue Cross Life and Health under this *plan*. Failure to give such notice to Anthem Blue Cross Life and Health or cooperate with Anthem Blue Cross Life and Health, or actions that prejudice the rights or interests of Anthem Blue Cross Life and Health will be a material breach of this *plan* and will result in them being personally responsible for reimbursing Anthem Blue Cross Life and Health.

3. Anthem Blue Cross Life and Health will be entitled to collect on our lien even if the amount the *insured person*, or anyone acting for them (the *insured person's* estate, parent or legal guardian), recovered from or for the account of such third party as compensation for the injury, illness or condition less than the actual loss the *insured person* suffered.

EXCESS COVERAGE

We will reduce the amount payable under this *plan* to the extent expenses are covered under any other plan. We will determine the amount of benefits provided by other plans without reference to any coordination of benefits, non-duplication of benefits, or other similar provisions. The amount from other plans includes any amount to which the *insured person* is entitled, whether or not a claim is made for the benefits. This *policy* is secondary coverage to all other policies, except as required by state or federal law.

UTILIZATION REVIEW PROGRAM

Benefits are provided only for *medically necessary* and appropriate services. Utilization Review is designed to work together with the *insured person* and their provider to ensure they receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless the *insured person's* coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this *plan*.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this *plan* is secondary to another plan providing benefits for an *insured persons*.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. The *insured person* and their *physician* are advised if we have determined that services can be safely provided in an outpatient setting, or if an inpatient *stay* is recommended. Services that are *medically necessary* and appropriate are certified by us and monitored so that the *insured person* knows when it is no longer *medically necessary* and appropriate to continue those services.

This *plan* includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This *plan* requires that covered services be *medically necessary* for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. *Participating providers* will initiate the review on the *insured person's* behalf. A *non-participating provider* may or may not initiate the review for the *insured person*. In both cases, it is the *insured person's* responsibility to initiate the process and ask their *physician* to request pre-service review. The *insured person's* may also call us directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not *medically necessary* if the *insured person* has not previously tried alternative treatments that are more cost effective.

It is the *insured person's* responsibility to determine whether a particular service requires pre-service authorization. To assist the *insured person*, read the following information that follows in this determination and visit www.anthem.com or call the toll-free number for pre-service for any questions about making this determination.

It is also the *insured person's* responsibility to see that their *physician* starts the utilization review process before scheduling the *insured person* for any service subject to the utilization review program. If the *insured person* receives any such service, and does not follow the procedures set forth in this section, the *insured person's* benefits will be reduced as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

The stages of utilization reviews are pre-service review, care coordination review, and retrospective review:

Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for services listed below.

- Scheduled, non-emergency inpatient *hospital stay*.
- Specific, non-emergency outpatient services, including diagnostic treatment and other services.

- Specific outpatient surgeries performed in an outpatient facility or a doctor's office.
- Air ambulance in a non-medical *emergency*.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy, Physical Medicine and Occupational Therapy" provision of MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Specific durable medical equipment.
- Home health care.
- Admissions to a *skilled nursing facility*.

Care coordination review determines whether services are *medically necessary* and appropriate when Anthem Blue Cross Life and Health is notified while service is ongoing, for example, an *emergency* admission to the *hospital*.

Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or care coordination review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

EFFECT ON BENEFITS

In order for the full benefits of this *plan* to be payable, the following criteria must be met:

1. When pre-service review is performed and the admission, procedure or service is determined to be *medically necessary* and appropriate, benefits will be provided for the following:
   - Scheduled, non-emergency inpatient *hospital stay*.
   - Specific, non-emergency outpatient services, including diagnostic treatment and other services.
   - Specific outpatient surgeries performed in an outpatient facility or a doctor's office.
   - Air ambulance in a non-medical *emergency*.
   - A specified number of additional visits for physical therapy, physical medicine and occupational therapy if the *insured person* needs more visits than is provided under the "Physical Therapy, Physical Medicine or Occupational Therapy" provision of MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
   - Specific durable medical equipment.
   - Home health care services if:
     a. The services can be safely provided in the *insured person's* home, as certified by their attending physician;
     b. The *insured person's* attending *physician* manages and directs their medical care at home; and
     c. The *insured person's* attending *physician* has established a definitive treatment plan which must be consistent with the *insured person's* medical needs and lists the services to be provided by the home health agency.

- Services provided in a skilled nursing facility if the *insured person* requires daily skilled nursing or rehabilitation, as certified by their attending *physician*.

If the *insured person* proceeds with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

2. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be provided for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always the *insured person's* responsibility to confirm that the review has been performed. If the review is not performed the *insured person's* benefits will be reduced as shown in the "Effect on Benefits".

Pre-service Reviews. Penalties will result for failure to obtain required pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, the *insured person* or their *physician* must initiate the pre-service review at least five working days prior to when the *insured person* is scheduled to receive services.

2. The *insured person* must tell their *physician* that this *plan* requires pre-service review. *Physicians* who are *participating providers* will initiate the review on the *insured person's* behalf. A *non-participating provider* may initiate the review for the *insured person*, or the *insured person* may call Anthem Blue Cross Life and Health directly.

3. If the *insured person* does not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. Anthem Blue Cross Life and Health will determine if services are *medically necessary* and appropriate. For inpatient *hospital stays*, Anthem Blue Cross Life and Health will, if appropriate, specify a specific length of *stay* for services. The *insured person*, their *physician* and the provider of the service will receive a written confirmation showing this information.

Care Coordination Reviews

1. If pre-service review was not performed, the *insured person*, the *insured person's physician* or the provider of the service should contact Anthem Blue Cross Life and Health for service review. For an *emergency* admission or procedure, Anthem Blue Cross Life and Health must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When *participating providers* have been informed of the *insured person's* need for utilization review, they will initiate the review on the *insured person's* behalf. The *insured person* may ask a *non-participating provider* to call, or the *insured person* may call directly.

3. When Anthem Blue Cross Life and Health determines that the service is *medically necessary* and appropriate, the Anthem Blue Cross Life and Health will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. Anthem Blue Cross Life and Health will also determine the medically appropriate setting.

4. If Anthem Blue Cross Life and Health determines that the service is not *medically necessary* and appropriate, the *insured person* and the *insured person's physician* will be notified by telephone no later than 24 hours following Anthem Blue Cross Life and Health's decision. Anthem Blue Cross Life and Health will send written notice to the *insured person* and the *insured person's physician* within two business days following their decision. However, care will not be discontinued until the *insured person's physician* has been notified and a plan of care that is appropriate for the *insured person's* need has been agreed upon.

*__Extraordinary Circumstances.__ In determining "extraordinary circumstances", Anthem Blue Cross Life and Health may take into account whether or not the *insured person* condition was severe enough to prevent the *insured person* from notifying Anthem Blue Cross Life and Health, or whether or not a member of the *insured person's* family was available to notify Anthem Blue Cross Life and Health for them. The *insured person* may have to prove that such "extraordinary circumstances" were present at the time of the *emergency*.

Retrospective Reviews

1. Retrospective review is performed when Anthem Blue Cross Life and Health has not been notified of the service the *insured person* received, and is therefore unable to perform the appropriate review prior to the *insured person's* discharge from the *hospital* or completion of outpatient treatment. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.

2. Such services which have been retroactively determined to not be *medically necessary* and appropriate will be retrospectively denied certification.

UTILIZATION REVIEW PROGRAM

THE MEDICAL NECESSITY REVIEW PROCESS

Anthem Blue Cross Life and Health works with the *insured person* and the *insured person's* health care providers to cover *medically necessary* and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem Blue Cross Life and Health is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains Anthem Blue Cross Life and Health's review process.

1. A decision on the medical necessity of a pre-service request will be made no later than five business days from receipt of the information reasonably necessary to make the decision, and based on the nature of the *insured person's* medical condition.

   When the *insured person's* medical condition is such that he or she faces an imminent and serious threat to his or her health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to his or her life or health or could jeopardize his or her ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

2. A decision on the medical necessity of a care coordination request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of the *insured person's* medical condition. However, care will not be discontinued until the *insured person's physician* has been notified and a plan of care that is appropriate for the *insured person's* needs has been agreed upon.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to the *insured person* and the *insured person's physician*.

4. If Anthem Blue Cross Life and Health does not have the information they need, Anthem Blue Cross Life and Health will make every attempt to obtain that information from the *insured person* or the *insured person's physician*. If Anthem Blue Cross Life and Health is unsuccessful, and a delay is anticipated, Anthem Blue Cross Life and Health will notify the *insured person* and the *insured person's physician* of the delay and what Anthem Blue Cross Life and Health needs to make a decision. Anthem Blue Cross Life and Health will also inform the *insured person* of when a decision can be expected following receipt of the needed information.

5. All pre-service, care coordination and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem Blue Cross Life and Health's medical policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem Blue Cross Life and Health, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as *medically necessary*. Review Coordinators are able to approve most requests.

6. For pre-service and care coordination requests, written confirmation including the specific service determined to be *medically necessary* will be sent to the *insured person* and the *insured person's* provider no later than two business days after the decision, and the *insured person's* provider will be initially notified by telephone within 24 hours of the decision for pre-service and care coordination reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting *physician* is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, the *insured person's* provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not *medically necessary* and appropriate. The *insured person's physician* will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to the *insured person* and the requesting provider within two business days of the decision. This written notice will include:

   - an explanation of the reason for the decision,
   - reference of the criteria used in the decision to modify or not certify the request,
   - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
   - how to request reconsideration if the *insured person* or the *insured person's* provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party Anthem Blue Cross Life and Health chooses at their sole and absolute discretion.

10. The *insured person* or the *insured person's physician* may request copies of specific criteria and/or medical policy by calling customer service. Anthem Blue Cross Life and Health discloses their medical necessity review procedures to health care providers through provider manuals and newsletters.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are *medically necessary* is based on the clinical information provided. Payment is based on the terms of the *insured person's* coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- The *insured person* is not eligible for coverage when the service is actually provided.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- The *insured person's* coverage under this *plan* ends;
- The *policy* with the *group* terminates;
- The *insured person* reaches a benefit maximum that applies to the services in question;
- The *insured person's* benefits under the *plan* change so that the services in question are no longer covered or are covered in a different way.

PERSONAL CASE MANAGEMENT

The personal case management program enables Anthem Blue Cross Life and Health to authorize *insured persons* to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Anthem Blue Cross Life and Health, through a case manager, has the right to recommend an alternative plan of treatment which may include services not covered under this *plan*. Anthem Blue Cross Life and Health provides these services at its sole and absolute discretion. The *insured person* does not have a right to receive personal case management, nor does Anthem Blue Cross Life and Health have an obligation to provide it; we provide these services at our sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

Insured persons may be identified for possible personal case management through the *plan's* utilization review procedures, by the attending *physician*, *hospital* staff, or Anthem Blue Cross Life and Health claims reports. The *insured person* or the *insured person's* family may also call Anthem Blue Cross Life and Health.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. The *insured person* requires extensive long-term treatment;

2. Anthem Blue Cross Life and Health anticipates that such treatment utilizing services or supplies covered under this *plan* will result in considerable cost;

3. A cost-benefit analysis by Anthem Blue Cross Life and Health determines that the benefits payable under this *plan* for the alternative plan of treatment can be provided at a lower overall cost than the benefits the *insured person* would otherwise receive under this *plan*; and

4. The *insured person* (or the *insured person's* legal guardian) and the *insured person's physician* agree, in a letter of agreement, with Anthem Blue Cross Life and Health's recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan. If Anthem Blue Cross Life and Health determines that the *insured person's* needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A Anthem Blue Cross Life and Health case manager will review the medical records and discuss the *insured person's* treatment with the attending *physician*, the *insured person* and the *insured person's* family.

Anthem Blue Cross Life and Health makes treatment recommendations only; any decision regarding treatment belong to the *insured person* and the *insured person's physician*. The *group* will, in no way, compromise the *insured person's* freedom to make such decisions.

EFFECT ON BENEFITS

1. Any alternative benefits are accumulated toward any Medical Benefit Maximum.

2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem Blue Cross Life and Health has absolute discretion in deciding whether or not to substitute benefits for any *insured person*, which alternative may be offered and the terms of the offer.

3. Any authorization of services in lieu of benefits in a particular case in no way commits Anthem Blue Cross Life and Health to do so in another case or for another *insured person*.

4. The personal case management program does not prevent Anthem Blue Cross Life and Health from strictly applying the expressed benefits, exclusions and limitations of this *plan* at any other time or for any other *insured person*.

Note: Anthem Blue Cross Life and Health reserves 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.

DISAGREEMENTS WITH MEDICAL MANAGEMENT PROGRAM DECISIONS

1. If the *insured person* or their *physician* disagree with a decision, or question how it was reached, they or their *physician* may request reconsideration. Requests for reconsideration (either by telephone, or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on the *insured person's* written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If the *insured person*, their representative, or their *physician* acting on their behalf, find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to Anthem Blue Cross Life and Health.

3. If the appeal decision is still unsatisfactory, the *insured person's* remedy may be BINDING ARBITRATION. (See BINDING ARBITRATION.)

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, we may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in our discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, we may select certain qualifying health care providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt claims from medical review if certain conditions apply.

If we exempt a process, health care provider, or claim from the standards that would otherwise apply, we are in no way obligated to do so in the future, or to do so for any other health care provider, claim, or *insured person*. We may stop or modify any such exemption with or without advance notice.

The *insured person* may determine whether a health care provider participates in certain programs by checking our online provider directory on our website at **www.anthemcom/ca** or by calling customer service.

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Anthem Blue Cross Life and Health's Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

STUDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

FOR STUDENTS ONLY

Benefits will be paid if the *insured person* sustains accidental loss of life, sight, hand, or foot. Loss of sight means total and permanent loss of sight. Loss of hand or foot means loss by severance at or above the wrist or ankle.

Those benefits are payable only if all of these conditions are met:

- The *insured person* sustains an accidental bodily *injury* while covered under this *plan*.
- The loss results directly from that *injury* and from no other cause.
- The *insured person* suffers the loss within 90 days after the accident.

Not all such losses are covered. See EXCLUSIONS Below.

Benefit Amount Payable. The amount payable depends on the type of loss as shown in the table. All benefits are subject to the Limitation per Accident below.

For Loss of:	Benefit Amount Payable
Life	$10,000
One Hand One Foot Sight of One Eye	$1,000
Both Hands Both Feet Sight of Both Eyes One Hand and One Foot One Hand and Sight of One Eye One Foot and Sight of One Eye	$5,000

Limitation Per Accident: Benefits under this coverage will only be paid for one specific loss which resulted from *injuries* sustained in the same accident. The Benefit Amount Payable will be for the loss which results in the greatest amount payable.

EXCLUSIONS

No benefit will be paid by this coverage for a death or loss that results from, or that is caused directly, wholly or partly by:

1. An *illness* or mental *illness*.
2. Medical or surgical treatment of *illness*, whether the loss results directly or indirectly from the treatment;
3. Any infection, unless it is pyogenic and occurs through and at the time of an accidental cut or wound;
4. Suicide or attempted suicide, while sane or insane.
5. Intentional self-injury.
6. Commission of, or attempt to commit, an assault or felony.

7. A war, or any act of war.

   “War” means declared or undeclared war and includes resistance to armed aggression.

8. Participation in a riot.

   “Riot” means all forms of public violence, disorder, or disturbance of the public peace by three or more persons assembled together. It does not matter whether there was common intent or not and it does not matter whether or not damage to person or property or unlawful act was the intent or the consequence of such disorder.

9. Being under the influence of any drug or substance. Conviction is not necessary for determination of being under the influence. This does not apply if the *insured person* is using a drug or substance prescribed for them by a *physician*.

   “Drug or substance” means any drug, narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as such act now exists, or is amended from time to time.

10. Being intoxicated. Conviction is not necessary for determination of being intoxicated.

    “Intoxicated” means being legally intoxicated as determined by the laws of the jurisdiction where the accident occurred.

11. Movement on or above the ground by means of an aircraft, or descent from or with a moving aircraft. This 11. applies only if:

    a. The *insured person has* any duties aboard the aircraft that relate in any way to that aircraft or its operation, equipment, passengers, or crew; or

    b. The *insured person is* giving or receiving training for any of those duties aboard that aircraft;

    “Aircraft” means any kind of vehicle or device designed for travel or other movement in or beyond the earth’s atmosphere.

BENEFICIARY

The *insured person* alone has the right to name their "*beneficiary*". That term means the person or persons to whom the death benefit will be paid. The *insured person* may change beneficiaries at any time. To do so, written notice must be given to the *group* for entry in the *plan's* records. Then, the change will be effective on the date of the notice. But, if the *insured person* dies before the notice is recorded, any death benefit we may have already paid will be deducted from the amount payable to the new *beneficiary*.

If the *insured person* names more than one person to share any death benefit, the *insured person* should tell how the benefit is to be divided among them. Otherwise, they will share the benefit equally. All rights of any *beneficiary* cease if he or she dies before the *insured person* does. If there is no living *beneficiary* when the *insured person’s* death occurs, or none has been named, the death benefit will be paid to their estate.

HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

Insured person. Each person will have a status as an *insured person* if they are included in the Classes of Persons Insured (See Schedule of Benefits).

ELIGIBILITY DATE

An *insured person* is eligible for coverage on the first day on which they are in the Classes of Persons Eligible.

EFFECTIVE DATE

An *insured person's* effective date of coverage is subject to the timely payment of premium charges on their behalf, and being in the Classes of Persons Eligible. If those conditions have been met, they are covered on the date those conditions were met.

HOW COVERAGE ENDS

An *insured person's* coverage ends without notice from Anthem Blue Cross Life and Health as provided below:

1. If the *policy* between the *group* and Anthem Blue Cross Life and Health terminates, coverage ends at the same time. But, this item 1 will not terminate coverage in connection with:

   a. an *accidental injury,* which occurred while covered, prior to the end of the one *year* period commencing on the date of the *accidental injury;* or

   b. an *emergency illness,* which occurred while covered, prior to the end of the *semester* in which it occurs.

   This *policy* may be canceled or changed without notice to *members*.

2. If the *group* no longer provides coverage for the class of *insured person's* to which a person belongs, their coverage ends on the effective date of that change. But, this item 2 will not terminate coverage in connection with:

   a. an *accidental injury,* which occurred while covered, prior to the end of the one *year* period commencing on the date of the *accidental injury;* or

   b. an *emergency illness,* which occurred while covered, prior to the end of the *semester* in which it occurs.

3. Coverage ends at the end of the period for which premium charges have been paid to Anthem Blue Cross Life and Health on the *insured person's* behalf when the required premium charges for the next period are not paid.

4. If the *insured person* no longer meet the requirements set forth in the "Eligible Status" provision of HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS, their coverage ends as of the date they cease to meet such requirements.

If an *insured person* has a question about eligibility, benefits under this *plan*, or concerning a claim, they may call customer service or they may write to Anthem Blue Cross Life and Health (please address all correspondence to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department shown in the Information Bulletin). Anthem Blue Cross Life and Health's customer service staff will answer the *insured person's* questions or assist them in resolving their issue.

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is *experimental* or *investigative*, the *insured person* may ask that the denial be reviewed by an external independent medical review organization contracting with the California Department of Insurance ("CDI"). The *insured person's* request for this review may be submitted to the CDI. The *insured person* pays no application or processing fees of any kind for this review. The *insured person* has the right to provide information in support of their request for review. A decision not to participate in this review process may cause the *insured person* to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send the *insured person* an application form and an addressed envelope for the *insured person* to use to request this review with any grievance disposition letter denying coverage for this reason. The *insured person* may also request an application form by calling customer service or write to us at Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310. To qualify for this review, all of the following conditions must be met:

- The *insured person* has a life-threatening or seriously debilitating condition, described as follows:
  - ♦ A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - ♦ A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The *insured person's physician* must certify that either (a) standard treatment has not been effective in improving their condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this *plan* than the proposed treatment.
- The proposed treatment must either be:
  - ♦ Recommended by a *participating provider* who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
  - ♦ Requested by the *insured person* or by a licensed board certified or board eligible *physician* qualified to treat the *insured person's* condition. The treatment requested must be likely to be more beneficial for the *insured person* than standard treatments based on two documents of scientific and medical evidence from the following sources:

    a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

    b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

    c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

g) Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

The *insured person* is not required to go through our grievance process for more than 30 days. If the *insured person's* grievance needs expedited review, the *insured person* is not required to go through our grievance process for more than three days.

The *insured person* must request this review within six months of the date they receive a denial notice from us in response to their grievance, or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

Within three business days of receiving notice from the CDI of the *insured person's* request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by the *insured person* or their *physician*. Any newly developed or discovered relevant medical records identified by us or by a *participating provider* after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if the *insured person's physician* determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Independent Medical Review of Grievances Involving a Disputed Health Care Service

The *insured person* may request an independent medical review ("IMR") of disputed health care services from the California Department of Insurance ("CDI") if the *insured person* believes that Anthem Blue Cross Life and Health has improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under the *insured person's plan* that has been denied, modified, or delayed by Anthem Blue Cross Life and Health, 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 the *insured person*. The *insured person* pays no application or processing fees of any kind for IMR. The *insured person* has the right to provide information in support of the request for IMR. Anthem Blue Cross Life and Health must provide the *insured person* with an IMR application form and an addressed envelope for the *insured person* to use to request IMR with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause the *insured person* to forfeit any statutory right to pursue legal action against Anthem Blue Cross Life and Health regarding the disputed health care service.

Eligibility: The CDI will review the *insured person's* application for IMR to confirm that:

1. (a) The *insured person's* provider has recommended a health care service as *medically necessary*, or

   (b) The *insured person* has received *urgent care* or *emergency services* that a provider determined was *medically necessary*, or

   (c) The *insured person* has been seen by a *participating provider* for the diagnosis or treatment of the medical condition for which the *insured person* seeks independent review;

2. The disputed health care service has been denied, modified, or delayed by Anthem Blue Cross Life and Health, based in whole or in part on a decision that the health care service is not *medically necessary*; and

3. The *insured person* has filed a grievance with Anthem Blue Cross Life and Health and the disputed decision is upheld or the grievance remains unresolved after 30 days. If the *insured person's* grievance requires expedited review the *insured person* need not participate in Anthem Blue Cross Life and Health's grievance process for more than three days. The CDI may waive the requirement that the *insured person* follow Anthem Blue Cross Life and Health's grievance process in extraordinary and compelling cases.

The *insured person* must apply for IMR within six months of the date the *insured person* receives a denial notice from Anthem Blue Cross Life and Health in response to the *insured person's* grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

If the *insured person's* case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists who will make an independent determination of whether or not the care is *medically necessary*. The *insured person* will receive a copy of the assessment made in their case. If the IMR determines the service is *medically necessary*, Anthem Blue Cross Life and Health will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within 30 days of receipt of the *insured person's* application and supporting documents. For urgent cases involving an imminent and serious threat to the *insured person's* 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 the *insured person's* health, the IMR organization must provide its determination within 3 days.

For more information regarding the IMR process, or to request an application form, please call customer service.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this *policy*, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

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 *insured person* and Anthem Blue Cross Life and Health agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

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

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

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

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

Please send all Binding Arbitration demands in writing to Anthem Blue Cross Life and Health Insurance Company, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Customer Service Department.

DEFINITIONS

The meanings of key terms used in this *policy* are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this *policy*, refer to this DEFINITIONS section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. In the case of an athlete or a high risk *student*, it is also a physiological malfunction, such as athlete's heart, heat stroke, heart block, embolism, stress fracture, et cetera, which may not be the direct result of an accidental injury, but, satisfactory evidence is provided to Anthem Blue Cross Life and Health that the physical malfunction occurred while the athlete was participating in intercollegiate athletics or the high risk student was participating in a police or fire academy program. The physical harm, disability, or physical malfunction must have occurred at an identifiable time and place. Accidental injury does not, otherwise, include illness or infection, except infection of a cut or wound.

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

Authorized referral occurs when the *insured person*, because of their medical needs, is referred to a *non-participating provider*, but only when:

- There is no *participating provider* who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 30-mile radius of their residence or within the county in which the *insured person's* residence is located, whichever is less;

- The *insured person* is referred in writing to the *non-participating provider* by the *physician* who is a *participating provider*, and

- The referral has been authorized by Anthem Blue Cross Life and Health before services are rendered.

The *insured person* or their *physician* must call customer service prior to scheduling an admission to, or receiving the services of, a *non-participating provider*.

Beneficiary means a person or entity named, in a form and manner approved by us, to receive benefits for loss of life.

Child is the student's unmarried natural child, stepchild, or legally adopted child, subject to the following:

1. The unmarried *child* is under 19 years of age.

2. A child who is in the process of being adopted is considered a legally adopted child if Anthem Blue Cross Life and Health receives legal evidence of both: (i) the intent to adopt; and (ii) that the *student* has either: (a) the right to control the health care of the child; or (b) assumed a legal obligation for full or partial financial responsibility for the child in anticipation of the child's adoption. Legal evidence to control the health care of the child means a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or relinquishment form, signed by the child's birth parent, or other appropriate authority, or in the absence of a written document, other evidence of the *student's* right to control the health care of the child.

Child of student in Child Care Facility activities means a child performing those activities customarily performed by a child in a supervised child care facility.

Class 1 and Class 2 athletic activities are determined by the sport the athlete is actually training, practicing or participating in, under supervision of an authorized representative of the college, including *club activities*, as follows:

1. Class 1 - football, soccer, wrestling, surfing, gymnastics, and skiing.

2. Class 2 - all other sports.

Club Activities are those activities or events normally performed, or staged, by a club approved by the college board and supervised by the college. The activities or events performed, or staged, by the club may be athletic activities or non-athletic activities.

Contracting hospital is a *hospital* which has a Standard Hospital Contract in effect with Anthem Blue Cross, an affiliate of Anthem Blue Cross Life and Health, to provide care to *insured persons* covered by Anthem or any of its affiliates. A contracting hospital is not necessarily a *participating provider*. A list of contracting hospitals will be sent on request.

Creditable coverage is any individual or group plan that provides medical, hospital and surgical coverage, including continuation or conversion coverage, coverage under Medicare or Medicaid, TRICARE, the Federal Employees Health Benefits Program, programs of the Indian Health Service or of a tribal organization, a state health benefits risk pool, coverage through the Peace Corps, the State Children's Health Insurance Program, or a public health plan established or maintained by a state, the United States government, or a foreign country. Creditable coverage does not include accident only, credit, coverage for on-site medical clinics, disability income, coverage only for a specified disease or condition, hospital indemnity or other fixed indemnity insurance, Medicare supplement, long-term care insurance, dental, vision, workers' compensation insurance, automobile insurance, no-fault insurance, or any medical coverage designed to supplement other private or governmental plans. Creditable coverage is used to reduce the length of the *pre-existing condition* exclusion period under this *plan*.

If the *insured person's* prior coverage was through an employer, the *insured person* will receive credit for that coverage if it ended because the *insured person's* employment ended, the availability of medical coverage offered through employment or sponsored by the employer terminated, or the employer's contribution toward medical coverage terminated, and any lapse between the date that coverage ended and the date the *insured person* becomes eligible under this *plan* is no more than 180 days (not including any waiting period imposed under this *plan*).

If the *insured person's* prior coverage was not through an employer, the *insured person* will receive credit for that coverage if any lapse between the date that coverage ended and the date the *insured person* becomes eligible under this *plan* is no more than 63 days (not including any waiting period imposed under this *plan*).

Custodial care is care provided primarily to meet the *insured person's* personal needs. This includes help in walking, bathing or dressing. It also includes: preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If *medically necessary*, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Effective date is the date an *insured person's* coverage begins under this *plan*.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain) which the *insured person* reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with us.

Emergency illness is an *emergency* which does not involve an accidental injury.

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric *emergency*.

Expanded Medical Coverage in the case of an athlete or a high risk *student,* it is also a physiological malfunction, such as athlete's heart, heat stroke, heart block, embolism, stress fracture, et cetera, which may not be the direct result of an accidental injury, but, satisfactory evidence is provided to Anthem that the physical malfunction occurred while the athlete was participating in intercollegiate athletics or the high risk student was participating in a police or fire academy program. The physical harm or physical malfunction must have occurred at an identifiable time and place. Accidental injury does not, otherwise, include illness or infection, except infection of a cut or wound.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Group refers to the business entity to which Anthem Blue Cross Life and Health has issued this *policy*.

Home health agencies are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the *insured person's* home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

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

For the limited purpose of inpatient care for the treatment of *severe mental disorders*, the term "hospital" includes *psychiatric health facilities*.

Illness is any disorder of the body or mind of an *insured person,* but, not an *injury*; pregnancy, of an *insured person*, including abortion, miscarriage or childbirth.

Injury is physical harm to the body of an *insured person*. Injury does not include illness or infection (unless it is pyogenic and occurs through and at the time of an accidental cut or wound).

Insured person is an individual included in the Classes of Persons Insured in the SCHEDULE OF BENEFITS.

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

Maximum allowed amount is the maximum amount of reimbursement we will allow for covered medical services and supplies under this *plan*. See MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Medically necessary procedures, services, equipment or supplies are those considered to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the *insured person*, the *insured person's physician* or another provider;
5. Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of the patient's illness, injury, or condition; and
6. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the *insured person* with the particular medical condition being treated than other possible alternatives; and

b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

c. For *hospital stays*, acute care as an inpatient is necessary due to the kind of services the *insured person* is receiving or the severity of their condition, and safe and adequate care cannot be received by them as an outpatient or in a less intensified medical setting.

Non-contracting hospital is a *hospital* which does not have a Standard Hospital Contract in effect with Anthem Blue Cross Life and Health at the time services are rendered.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross Life and Health at the time services are rendered:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*
- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A hospice
- A licensed ambulance company

They are not *participating providers*. Remember that the *maximum allowed amount* may only represent a portion of the amount which a *non-participating provider* charges for services. See MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Official visitor activities are: (1) conducting research or addressing the faculty and/or *students*; or (2) in the case of a *child,* attending “Mommy and me” classes with their *student* parent . These activities must take place on college grounds, in college leased or rented buildings, on or off campus, during the time classes are college authorized and calendared, and while at other locations as required by college sponsored and supervised activities.

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

The provider must be licensed according to state and local laws to provide covered medical services.

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with us at the time services are rendered:

- A *hospital*
- A *physician*
- An *ambulatory surgical center*

- A *home health agency*
- A facility which provides diagnostic imaging services
- A durable medical equipment outlet
- A *skilled nursing facility*
- A clinical laboratory
- A hospice
- A licensed ambulance company

Participating providers agree to accept the *maximum allowed amount* as payment for covered services. A directory of *participating providers* is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this *policy*, and when benefits would be provided if the services were provided by a physician as defined above:

   - A dentist (D.D.S. or D.M.D.)
   - An optometrist (O.D.)
   - A dispensing optician
   - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   - A licensed clinical psychologist
   - A chiropractor (D.C.)
   - An acupuncturist (A.C.)
   - A clinical social worker (L.C.S.W.)
   - A marriage and family therapist (M.F.T.)
   - A physical therapist (P.T. or R.P.T.)*
   - A speech pathologist*
   - An audiologist*
   - An occupational therapist (O.T.R.)*
   - A respiratory care practitioner (R.C.P.)*
   - A *psychiatric mental health nurse* (R.N.)*
   - A nurse midwife**
   - A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note:** The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a *participating provider* in the *insured person's* area, they may call customer service for a referral to an OB/GYN.

Plan is the set of benefits described in this *policy* and endorsements to it (if any). This plan is subject to the terms and conditions of this *policy* .

Policy is the Group Policy we have issued to the *group*.

Pre-existing condition means an illness, injury or condition which existed during the six-month period immediately prior to the *insured person's effective date*. A condition is considered to have existed when the *insured person*: (1) sought or received medical advice for that condition; (2) received medical care or treatment for that condition; or (3) received medical supplies, drugs or medicines for that condition.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;

2. Qualified to provide short-term inpatient treatment according to state law;

3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and

4. Staffed by an organized medical or professional staff which includes a *physician* as medical director.

Reasonable charge is a charge we consider not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Semester is a period of time equal to half a school year, with beginning and ending dates established by, the college. For the purpose of this definition, it may also be two consecutive quarters of a school year with beginning and end dates established by the college.

Severe mental disorders include the following psychiatric diagnoses specified in California Insurance Code section 10144.5: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

"Severe mental disorders" also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Benefits for severe mental disorders will be provided according to the *plan's* benefits for medical conditions.

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

Special care units are special areas of a *hospital* which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

Stay is an inpatient confinement which begins when the *insured person* is admitted to a facility and ends when they are discharged from that facility.

Student is a person enrolled at a college as such.

Student activities mean:

1. taking part in an activity sponsored and supervised by the college, including club activities and events; or

2. traveling straight to or from the activity as a member of a group under the college's supervision. If the travel is by means of aircraft, we will cover the *insured person* only while riding as a passenger in (including getting on or off) any scheduled or chartered aircraft of any civilian commercial airline authorized to provide regular passenger service between named cities at regular and specified times.

The activities specified above must take place on college grounds, in college leased or rented buildings, on or off campus, during the time classes are college authorized and calendared, and while at other locations as required by college sponsored and supervised activities.

Urgent care is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

We (us, our) refers to Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) or Anthem Blue Cross (an affiliate of Anthem Blue Cross Life and Health).

Year is a 12 month period starting on the date of an accidental injury.

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross Life and Health introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California *insured persons* with limited English proficiency.

The Language Assistance Program makes it possible for the *insured person* to access oral interpretation services and certain written materials vital to understanding the *insured person's* health coverage at no additional cost to the *insured person*.

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

Requesting a written or oral translation is easy. Just contact Member Services by calling customer service to update your language preference, to receive future translated documents, or to request interpretation assistance. Anthem Blue Cross Life and Health also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through **711.**

For more information about the Language Assistance Program visit www.anthem.com/ca.

COMPLAINT NOTICE

Should the *insured person* have any complaints or questions regarding their coverage, and this *policy* was delivered by a broker, the *insured person* should first contact the broker. You may also contact Anthem Blue Cross Life and Health at:

Anthem Blue Cross Life and Health Insurance Company
Customer Service
21215 Burbank Blvd.
Woodland Hills, CA 91367

866-811-7946

If the problem is not resolved, the *insured person* may also contact the California Department of Insurance at:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

1-800-927-HELP (4357) – In California

1-213-897-8921 – Out of California

1-800-482-4833 – Telecommunication Device for the Deaf

E-mail Inquiry: "Consumer Services" link at
www.insurance.ca.gov

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

  The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

  For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

  - Life Insurance
    80% of death benefits but not to exceed $300,000
    80% of cash surrender or withdrawal values but not to exceed $100,000

  - Annuities and Structured Settlement Annuities
    80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1067.02(b)(2)(C)

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street Los
Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.