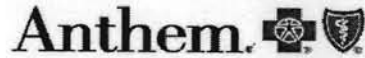


Includes Prescription Coverage



CENTURY PREFERRED DIRECT
 Effective September 18, 2010
 PPACA-Compliant: Non-Grandfathered Option

with \$10 Generic/\$25 Listed Brand/\$40 Non-Listed Brand Copay Prescription Drug Plan with Unlimited Annual Max

| | \$1500/\$3000 100%/60% | | | |
|-------|------------------------|------------|------------|------------|
| | Single | | Two - | |
| | Male | Female | Person | Family |
| 19-24 | \$260.97 | \$370.00 | \$675.42 | \$1,150.33 |
| 25-29 | \$260.97 | \$370.00 | \$675.42 | \$1,150.33 |
| 30-34 | \$347.79 | \$425.83 | \$686.80 | \$1,302.26 |
| 35-39 | \$347.79 | \$425.83 | \$686.80 | \$1,302.26 |
| 40-44 | \$449.08 | \$469.23 | \$762.75 | \$1,394.76 |
| 45-49 | \$519.87 | \$526.59 | \$857.84 | \$1,458.84 |
| 50-54 | \$707.45 | \$727.61 | \$1,241.28 | \$1,726.01 |
| 55-59 | \$925.02 | \$918.81 | \$1,621.11 | \$2,089.83 |
| 60-64 | \$1,242.83 | \$1,097.10 | \$2,056.75 | \$2,463.95 |
| 65+ | \$1,202.52 | \$1,065.58 | \$2,036.60 | \$2,339.42 |

| | \$3000/\$6000 100%/60% | | | | \$5000/\$10000 100%/60% | | | | \$10000/\$20000 100%/60% | | | |
|-------|------------------------|----------|------------|------------|-------------------------|----------|------------|------------|--------------------------|----------|------------|------------|
| | Single | | Two - | | Single | | Two - | | Single | | Two - | |
| | Male | Female | Person | Family | Male | Female | Person | Family | Male | Female | Person | Family |
| 19-24 | \$210.43 | \$298.34 | \$544.62 | \$927.55 | \$173.87 | \$246.50 | \$449.98 | \$766.39 | \$151.71 | \$215.10 | \$392.65 | \$668.73 |
| 25-29 | \$210.43 | \$298.34 | \$544.62 | \$927.55 | \$173.87 | \$246.50 | \$449.98 | \$766.39 | \$151.71 | \$215.10 | \$392.65 | \$668.73 |
| 30-34 | \$280.43 | \$343.35 | \$553.78 | \$1,050.06 | \$231.71 | \$283.69 | \$457.56 | \$867.60 | \$202.18 | \$247.55 | \$399.27 | \$757.05 |
| 35-39 | \$280.43 | \$343.35 | \$553.78 | \$1,050.06 | \$231.71 | \$283.69 | \$457.56 | \$867.60 | \$202.18 | \$247.55 | \$399.27 | \$757.05 |
| 40-44 | \$362.10 | \$378.35 | \$615.03 | \$1,124.64 | \$299.18 | \$312.61 | \$508.17 | \$929.24 | \$261.07 | \$272.78 | \$443.42 | \$810.83 |
| 45-49 | \$419.19 | \$424.61 | \$691.70 | \$1,176.32 | \$346.35 | \$350.83 | \$571.52 | \$971.94 | \$302.22 | \$306.12 | \$498.70 | \$848.09 |
| 50-54 | \$570.45 | \$586.69 | \$1,000.90 | \$1,391.75 | \$471.33 | \$484.75 | \$826.98 | \$1,149.93 | \$411.27 | \$422.99 | \$721.61 | \$1,003.40 |
| 55-59 | \$745.88 | \$740.87 | \$1,307.17 | \$1,685.09 | \$616.28 | \$612.15 | \$1,080.05 | \$1,392.31 | \$537.76 | \$534.15 | \$942.42 | \$1,214.91 |
| 60-64 | \$1,002.15 | \$884.64 | \$1,658.43 | \$1,986.77 | \$828.01 | \$730.92 | \$1,370.27 | \$1,641.57 | \$722.51 | \$637.79 | \$1,195.67 | \$1,432.40 |
| 65+ | \$969.64 | \$859.22 | \$1,642.18 | \$1,886.36 | \$801.16 | \$709.92 | \$1,356.86 | \$1,558.60 | \$699.08 | \$619.47 | \$1,183.96 | \$1,360.00 |

Unlimited Prescription Coverage- Copays are 10/25/40

For information or assistance call 1-866-508-0618

NO Prescription Coverage



CENTURY PREFERRED DIRECT
 Effective September 18, 2010
 PPACA-Compliant: Non-Grandfathered Option

Medical only - No Drug Benefit

| | \$1500/\$3000 80%/60% | | | |
|-------|-----------------------|----------|------------|------------|
| | Single | | Two - | |
| | Male | Female | Person | Family |
| 19-24 | \$170.83 | \$242.19 | \$442.11 | \$752.97 |
| 25-29 | \$170.83 | \$242.19 | \$442.11 | \$752.97 |
| 30-34 | \$227.66 | \$278.72 | \$449.55 | \$852.41 |
| 35-39 | \$227.66 | \$278.72 | \$449.55 | \$852.41 |
| 40-44 | \$293.95 | \$307.14 | \$499.28 | \$912.96 |
| 45-49 | \$340.29 | \$344.69 | \$561.52 | \$954.92 |
| 50-54 | \$463.07 | \$476.26 | \$812.49 | \$1,129.78 |
| 55-59 | \$605.48 | \$601.42 | \$1,061.12 | \$1,367.92 |
| 60-64 | \$813.52 | \$718.13 | \$1,346.27 | \$1,612.82 |
| 65+ | \$787.12 | \$697.49 | \$1,333.08 | \$1,531.31 |

| | \$3000/\$6000 100%/60% | | | | \$5000/\$10000 100%/60% | | | | \$10000/\$20000 100%/60% | | | |
|-------|------------------------|----------|------------|------------|-------------------------|----------|----------|------------|--------------------------|----------|----------|----------|
| | Single | | Two - | | Single | | Two - | | Single | | Two - | |
| | Male | Female | Person | Family | Male | Female | Person | Family | Male | Female | Person | Family |
| 19-24 | \$145.35 | \$206.07 | \$376.19 | \$640.69 | \$108.79 | \$154.23 | \$281.55 | \$479.53 | \$86.63 | \$122.83 | \$224.22 | \$381.87 |
| 25-29 | \$145.35 | \$206.07 | \$376.19 | \$640.69 | \$108.79 | \$154.23 | \$281.55 | \$479.53 | \$86.63 | \$122.83 | \$224.22 | \$381.87 |
| 30-34 | \$193.70 | \$237.16 | \$382.51 | \$725.31 | \$144.98 | \$177.50 | \$286.29 | \$542.85 | \$115.45 | \$141.36 | \$228.00 | \$432.30 |
| 35-39 | \$193.70 | \$237.16 | \$382.51 | \$725.31 | \$144.98 | \$177.50 | \$286.29 | \$542.85 | \$115.45 | \$141.36 | \$228.00 | \$432.30 |
| 40-44 | \$250.11 | \$261.34 | \$424.82 | \$776.82 | \$187.19 | \$195.60 | \$317.96 | \$581.42 | \$149.08 | \$155.77 | \$253.21 | \$463.01 |
| 45-49 | \$289.55 | \$293.29 | \$477.78 | \$812.52 | \$216.71 | \$219.51 | \$357.60 | \$608.14 | \$172.58 | \$174.80 | \$284.78 | \$484.29 |
| 50-54 | \$394.03 | \$405.24 | \$691.35 | \$961.32 | \$294.91 | \$303.30 | \$517.43 | \$719.50 | \$234.85 | \$241.54 | \$412.06 | \$572.97 |
| 55-59 | \$515.20 | \$511.74 | \$902.90 | \$1,163.94 | \$385.60 | \$383.02 | \$675.78 | \$871.16 | \$307.08 | \$305.02 | \$538.15 | \$693.76 |
| 60-64 | \$692.22 | \$611.05 | \$1,145.53 | \$1,372.32 | \$518.08 | \$457.33 | \$857.37 | \$1,027.12 | \$412.58 | \$364.20 | \$682.77 | \$817.95 |
| 65+ | \$669.76 | \$593.49 | \$1,134.30 | \$1,302.97 | \$501.28 | \$444.19 | \$848.98 | \$975.21 | \$399.20 | \$353.74 | \$676.08 | \$776.61 |

No Prescription Coverage in above prices

For information or assistance call 1-866-508-0618

Century Preferred Direct (PPO)

~~XXXXXX~~

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. Upon enrollment, it is therefore important that you **READ YOUR POLICY CAREFULLY**.

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy.

Health Savings Account (HSA)-compatible products are shaded. This product is intended to be federally tax qualified. Approval by the Insurance Department does not guarantee tax qualification. Please seek the counsel of a tax advisor. This policy has not been submitted for approval by the IRS.

A Brief Description of Benefits

| Covered Service | In-Network Services (*Out-of-Network Services) | | | | | | |
|---|--|--------------|--------------|--------------|--------------|--------------|--------------|
| | Individual Deductible** | \$250 | \$1,500 | \$5,000 | \$10,000 | \$1,250 | \$2,500 |
| Family Deductible** | \$500 | \$3,000 | \$10,000 | \$20,000 | \$2,500 | \$5,000 | \$8,000 |
| Member In-Network Coinsurance (Member Out-of-Network Coinsurance) | 20% (40%) | N/A (20%) | N/A (20%) | N/A (20%) | N/A (20%) | N/A (20%) | N/A (20%) |
| Member Cost-Share Maximum | | | | | | | |
| Individual | \$1,500 | \$3,000 | \$10,000 | \$15,000 | \$2,500 | \$5,000 | \$5,000 |
| Family | \$3,000 | \$6,000 | \$20,000 | \$30,000 | \$5,000 | \$10,000 | \$10,000 |
| Lifetime Maximum | \$5,000,000 | | | | | | |
| Daily Hospital Room and Board | | | | | | | |
| All Inpatient Admissions | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | | | | | | |
| Inpatient Hospital Services In a Hospital or Residential Treatment Center for Mental Health Care | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | | | | | | |
| Inpatient Rehabilitation Treatment for Substance Abuse Care In a Hospital or Substance Abuse Treatment Facility | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | | | | | | |
| Skilled Nursing Facility up to 120 days per Calendar Year | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | | | | | | |
| Specialty Hospital 60 days per Member per Calendar Year <i>for other than Mental Health and Substance Abuse services only.</i> | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | | | | | | |
| Miscellaneous Hospital Services | | | | | | | |
| Emergency Room Treatment | Deductible and In-Network Coinsurance (Paid as In-Network Service) | | | | | | |
| Urgent Care Services | Deductible and In-Network Coinsurance (Paid as In-Network Service) | | | | | | |

*Out-of-Network Services are noted in parentheses.

**HSA Individual Member: The Deductible must be satisfied before any Covered Services will be paid by the Plan. HSA Family: The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services will be paid by the Plan.

For more information or assistance call 1-866-508-0618

| Covered Service | In-Network Services (*Out-of-Network Services) | |
|--|--|--|
| Surgical Services | | |
| Outpatient surgery In a licensed ambulatory surgical center (including colonoscopy) | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Medical Office Visit | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Anesthesia Services | | |
| Anesthesia, anesthesia supplies and services | Included in Hospital Services (Included in Hospital Services) | |
| In-Hospital Medical Services | | |
| Inpatient hospital/inpatient facility visits during a covered Admission | Included in Medical Services (Included in Medical Services) | |
| Services of a Physician or Surgeon <i>other than a medical office visit</i> | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Out-of-Hospital Care | | |
| Well Child Care 6 exams from birth to 1 year of age 6 exams 1 through 5 years of age 1 exam every 2 Calendar Years 6 through 10 years of age 1 exam every Calendar Year 11 through 21 years of age | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | No charge In-Network (Deductible and Out-of-Network Coinsurance) |
| Adult Physical Examinations 1 exam every 5 Calendar Years 22 through 29 years of age 1 exam every 3 Calendar Years 30 through 39 years of age 1 exam every 2 Calendar Years 40 through 49 years of age 1 exam per Calendar Year 50 years of age and older | | |
| Routine gynecological visit 1 visit per Calendar Year including pap smear | | |
| Mammography One baseline screening for female 35 through 39 years of age One screening mammogram every Calendar Year for female 40 and older Note: or more frequently if recommended | | |
| Other Benefits | | |
| Immunizations and Vaccinations includes those needed for travel | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | No charge In-Network (Deductible and Out-of-Network Coinsurance) |
| Hearing Exams 1 hearing exam every 2 Calendar Years | | |
| Diagnostic Services | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Infertility Services Office Visit Outpatient Hospital Inpatient Hospital | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Infertility drugs (with infertility diagnosis) The maximum supply of a drug for which Benefits will be provided when dispensed under any one prescription is a 30 day supply or 100 unit dose, whichever is greater. | Deductible and Out-of-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Outpatient Rehabilitation Services Restorative physical, occupational, speech therapy (maximum combined 30 visits per calendar year) Chiropractic therapy (maximum 20 visits per calendar year) | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |
| Other Therapy Services Outpatient cardiac rehabilitation therapy for up to 36 visits per cardiac episode | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) | |

*Out-of-Network Services are noted in parentheses.

For more information or assistance call 1-866-508-0618

| Covered Service | In-Network Services (*Out-of-Network Services) |
|--|--|
| Radiation therapy Chemotherapy for the treatment of cancer Electroshock Therapy Kidney Dialysis in a Hospital or free-standing dialysis center | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Allergy Testing and Treatment Allergy visits/testing Immunotherapy or other therapy treatments to a maximum of 80 visits over a 3 Calendar Year period | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Ambulance Services Maximum for land: Paid according to the Department of Public Health Ambulance Service Rate Schedule Maximum for air: Paid according to the Department of Public Health Air Ambulance Service Rate Schedule | Deductible and In-Network Coinsurance (Paid as an In-Network Service) |
| Outpatient Treatment for Mental Health Care and Substance Abuse Care | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Private Duty Nursing Limited to \$15,000 Per Calendar Year | Not applicable (Deductible and Out-of-Network Coinsurance) |
| Diabetic equipment, drugs and supplies purchased at a Pharmacy that is not a Durable Medical Equipment supplier | Covered according to prescription drug plan |
| Human Organ and Tissue Transplant Services \$1,000,000 Lifetime Maximum | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Home Health Care Nursing and therapeutic services limited to 200 visits Home health aide services limited to 80 visits that are applicable to the 200 visit limit | No cost share (\$50 deductible and 20% coinsurance) <i>For HSA-qualified plan: Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance)</i> (The deductible for Home Health Care benefits accrues towards the member's annual deductible) |
| Infusion Therapy Unlimited Lifetime Maximum | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Durable Medical Equipment Hearing Aid Coverage available for dependent children age 12 years and under with a maximum of \$1,000 within a two year period. | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Ostomy Related Services | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Hospice Care (inpatient) 60 days per Calendar Year. | Deductible and In-Network Coinsurance (Deductible and Out-of-Network Coinsurance) |
| Wig Up to \$350 maximum per member per calendar year | No cost share |
| Specialized Formula | \$20 copayment |
| Penalty for Failure to Prior Authorize Elective Hospital Admissions, Partial Hospitalizations or Day/Night Visit Programs or Authorize a Medical Emergency Admission within 2 business days Penalty for Failure to Prior Authorize Covered Services Please note that the combined penalty amount for Facility Benefit and the Admitting Physician Benefit will be no greater than \$500 | \$500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) (\$500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA)) \$500 Hospital and 25% Physician of Maximum Allowable Amount (MAA) (\$500 Hospital and 25% Physician) (of Maximum Allowable Amount (MAA)) |

*Out-of-Network Services are noted in parentheses.

Note: Services applicable after Deductible and Coinsurance. Member is responsible for the difference between Maximum Allowable Amount (MAA) and total charge.

BlueCare Direct and Century Preferred Direct exclusions and limitations

In addition to the other limitations, conditions and exclusions set forth elsewhere in this Certificate, no benefits will be provided for expenses related to the services, supplies, conditions or situations described in this section. These items and services are not covered even if you receive them from your Provider or according to your Provider's Referral.

Please remember, this plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem Blue Cross and Blue Shield (Anthem) is the final authority for determining if services or supplies are Medically Necessary.

The listed exclusions below are in addition to those set forth elsewhere in the Certificate.

The following services are not Covered Services under this Benefit Program, except when approved by Anthem as part of Case Management.

1. Benefits for services which are not:
 - a. specifically described in the Subscriber Agreement
 - b. rendered or ordered by a Physician
 - c. within the scope of the Physician's, Provider's or Hospital's licensure; and
 - d. Medically Necessary Care for the proper diagnosis and treatment of the Member.
2. Benefits may be reduced or denied if subject to the Managed Benefits — Managed Care Guidelines. Any reduced or denied benefits paid by the Member do not apply toward the Cost Share Maximums shown in the Schedule of Benefits.
3. Benefits for services rendered before the Member's Effective Date under this Benefit Program.
4. Benefits for services rendered after the person's Benefit Program has been rescinded, suspended, cancelled, interrupted or terminated. Any person obtaining services after his or her Benefit Program is rescinded, suspended, cancelled, interrupted or terminated for any reason will be solely responsible for payment of such services.
5. Care for conditions which are required by State or Local law to be treated in a public facility.
6. Services and care in a Veteran's Hospital or any Federal Hospital, except as may be otherwise required by law.
7. Services covered in whole or in part by public or private grants.
8. Services required by third parties, including but not limited to: school, employment, summer camp and premarital physicals and related tests.
9. Studies related to pregnancy except for significant medical reasons.
10. Simplified or self-administered tests and multiphasic screening.
11. Cosmetic Surgery or services performed primarily to improve appearance and not designed to restore body function or to correct deformity resulting from the treatment of malignancy or physical trauma.
12. Dental diagnosis, care, treatment, x-rays, or Appliances, for any of the diseases or lesions of the oral cavity, its contents or contiguous structures, the extraction of teeth, the correction of malpositions of the teeth and jaw, or for pain, deformity, deficiency, injury or physical condition of teeth, unless otherwise provided for in this Subscriber Agreement.
13. Surgical and non-surgical examination, diagnosis, including invasive (internal) and non-invasive (external) procedures and tests, and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. This exclusion includes but is not limited to the following: contrast and non-contrast imaging, arthroscopic and open surgical procedures, physical therapy, and appliance therapy such as occlusal Appliances (splints) or adjustments. Anthem will not provide benefits unless otherwise provided for by an Amendatory Rider to this Subscriber Agreement.
14. Routine foot care in the absence of systemic or vascular disease affecting the foot, including hygienic care, treatment of corns or calluses, services performed in conjunction with fitting of supportive or comfort devices for the foot or other foot care.

For more information or assistance call 1-866-508-0618

15. Services for Custodial Care, Chronic Care and/or Maintenance Care.
16. Prenatal medical conferences with a pediatrician regarding an unborn child unless the visit is the result of a medical referral.
17. Charges for the Member's room and board when the Member has a leave of absence from the Hospital, Substance Abuse Treatment Facility or other Inpatient Facility.
18. Drugs or medications, legend and over-the-counter, prescribed for use as an Outpatient, except as otherwise stated herein.
19. Evaluation, treatment, procedures and Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling.
20. Sperm collection and preservation, all services related to surrogate parenting arrangements and preparatory treatment.
21. For Century Preferred Direct, obstetrical care or pregnancy, delivery, prenatal and postpartum care, including Inpatient care for a female Member.
22.
 - a. For Century Preferred Direct, no benefits are available for sterilization or reversal of sterilization.
 - b. For Blue Care Direct, no benefits are available for reversal of sterilization.
23. Vaccines other than routine immunizations or those needed for travel.
24. Services, medical supplies or supplies not specifically listed as Covered Services. These include but are not limited to educational therapy, marital counseling, sex therapy, weight control programs, nutritional programs and exercise programs.
25. No benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition.
26. Experimental or Investigational treatment, procedure, facility, equipment, drugs, devices or supplies. Any services associated with or as follow-up to any of the above is not a Covered Service.
27. Any treatment, procedure, facility, equipment, drug, device or supply which requires Federal or other governmental agency approval not granted at the time services are rendered. Any service associated with, or as follow-up to, any of the above is not a Covered Service.
28. Any services by a Physician or Provider to himself or herself or for services rendered to his or her parent, spouse, children, grandchildren or any other immediate family Member or relation, even if a Participating Physician or Participating Provider. Services which the Member or Anthem is not legally required to pay.
29. Wigs, except as noted in the Covered Services Section.
30. Inpatient services which can be properly rendered as Outpatient services.
31. Disease contracted or injuries resulting from war.
32. Charges after the Provider's or Hospital's regular discharge hour on the day indicated for the Member's discharge by his/her Physician.
33. Charges in excess of the Maximum Allowable Amount.
34. Supervisory care by a Physician for a Member who is mentally or physically disabled and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing medical care; or when despite such treatment, there is no reasonable likelihood that the disability will be so reduced.
35. Travel, whether or not recommended by a Physician.
36. Certain pulmonary function tests which in the opinion of Anthem do not meet the definition of a covered diagnostic laboratory test.
37. Services or procedures rendered without regard for specific clinical indications, routinely for groups or individuals or which are performed solely for research purposes.
38. Services or procedures which have become obsolete or are no longer medically justified as determined by appropriate medical specialties.
39. Radiation therapy as a treatment for acne vulgaris.
40. Services rendered by a Physician in the employ of a Home (e.g. Skilled Nursing Facility) do not qualify as Home & Office Care.

For more information or assistance call 1-866-508-0618

continued >

BlueCare Direct and Century Preferred Direct exclusions and limitations (continued)

41. The following is a list of procedures which are not covered:

1. Allogeneic or Syngeneic Bone Marrow Transplant or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy and/or radiation) are those with a donor other than the patient. They are not covered except in the following cases:
 - a. When at least five out of six histocompatibility complex antigens match between the patient and the donor.
 - b. The mixed leukocyte culture is non-reactive.
 - c. One of the following conditions is being treated:
 - Severe aplastic anemia
 - Acute nonlymphocytic leukemia in first or subsequent remission or early first relapse
 - Myelodysplastic syndrome
 - Secondary acute nonlymphocytic leukemia as initial therapy
 - Acute lymphocytic leukemia in second or subsequent remission
 - Acute lymphocytic leukemia in first remission
 - Chronic myelogenous leukemia in chronic and accelerate phase
 - Non-Hodgkin's lymphoma, high grade, in first or subsequent remission
 - Hodgkin's lymphoma low grade, which has undergone conversion to high grade
 - Neuroblastoma, stage 3 or relapsed stage 4
 - Ewing's sarcoma
 - Severe combined immunodeficiency syndrome
 - Wiskott-Aldrich syndrome
 - Osteopetrosis, infantile malignant
 - Chediak-Higashi syndrome
 - Congenital life-threatening neutrophil disorders to include Kostmann's syndrome, chronic granulomatous disease, and cartilage hair hypoplasia
 - Diamond Blackfan syndrome
 - Thalassemia
 - Sickle cell anemia
 - Primary thrombocytopathy including Glanzmann's syndrome

- Gaucher disease
- Mucopolysaccharidoses and lipidoses to include Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome, Morquio's syndrome, Hunter's syndrome, and metachromatic leukodystrophy. All other uses of Allogeneic or Syngeneic Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with or without high dose chemotherapy or radiation) are not covered.

2. Autologous Bone Marrow Transplantation or other forms of stem cell rescue and stem cell infusion (in which the patient is the donor) with high dose chemotherapy or radiation are not covered except for the following:
 - a. Non-Hodgkin's lymphoma, high grade, first or subsequent remission. No morphological evidence of bone marrow involvement should be evident.
 - b. Hodgkin's disease as defined above with an absence of bone marrow involvement.
 - c. Acute nonlymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - d. Acute lymphocytic leukemia in second remission, in which no HLA matched donor exists or an allogeneic transplant is inappropriate.
 - e. Retinoblastoma, adjuvant setting after successful induction (consolidation).
 - f. Neuroblastoma, adjuvant setting after successful induction (consolidation). Autologous Bone Marrow Transplants or other forms of stem cell rescue and stem cell infusion (with high dose chemotherapy and/or radiation), for all other cases are not covered.

42. Pre-Existing Condition Limitation Exclusion- Century Preferred Direct does not cover Pre-Existing Conditions diagnosed or treated during the 6 months immediately preceding your Effective Date. The Pre-Existing Condition Limitation Period may last up to 12 months from your Enrollment Date. Credit from prior Creditable Coverage will be applied if applicable to reduce your specific Pre-Existing Condition Limitation Period. If applicable, you will be notified in writing by Anthem Blue Cross and Blue Shield exactly how many months you will be subject to this exclusion. This does not affect BlueCare Direct HMO.

For more information or assistance call 1-866-508-0618