Voluntary
Accident Insurance

Certificate of Coverage

Plan Sponsor: Veros Software Inc.
Policy: L06131
Class: 01
Class Description: All Eligible Employees

anthem.com

GROUP ACCIDENT INSURANCE CERTIFICATE
Non-Participating

Anthem Blue Cross Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Policyholder: Veros Software Inc.
Policy Number: L06131
Policy Effective Date: September 1, 2023
Policy Anniversary: September 1

We have issued the Policy to the Policyholder. The Policy is delivered in and governed by the laws of the state of California and to the extent applicable, by the Employee Retirement Income Security Act of 1974 (as amended). The provisions of the Policy that are important to the Covered Person(s) are summarized in this Certificate, consisting of this form and any additional forms which have been made a part of this Certificate. This Certificate replaces any other Certificate We may have previously issued to the Primary Insured under the Policy. The Policy alone is the only contract under which payment will be made. Any difference between the Policy and this Certificate will be settled according to the provisions of the Policy on file with Us at Our Home office. The Policy may be inspected at the office of the Policyholder.

Signed for Anthem Blue Cross Life and Health Insurance Company at Thousand Oaks, California.

Beth Andersen
President

Notice to Buyer: The Policy provides Accident-only coverage and it does not pay benefits for loss from sickness. Review Your Certificate carefully.

The Policy provides limited benefits. Benefits provided are not intended to cover all medical expenses.

This Policy may provide payment of several benefits as a result of claims from a single Accident. Payment of one benefit for a Covered Accident under this Policy does not constitute acceptance of liability for all claims made under the Policy nor does it prohibit Us from further investigation into the cause of or existence of a Covered Accident for subsequent claims.

THIS IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from Us.

READ THIS CERTIFICATE CAREFULLY. The Primary Insured has a 30-day right from the Coverage Effective Date to examine this Certificate. If the Primary Insured is not satisfied, it may be returned to Us within 30 days from receipt of this Certificate. In that event, We will consider it void from its effective date and any premiums paid will be refunded. Any claims paid under the Policy during the initial 30-day period will be deducted from the refund.

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in the Policy or refers to a specific provision contained herein.

TABLE OF CONTENTS

BENEFIT SCHEDULE

Policy Effective Date: September 1, 2023

Eligible Class(es)
Actively at work Employees who are scheduled to work at least 30 hours per week and who have satisfied any applicable eligibility waiting periods as defined by the policyholder.

Plan Type: 3 – Voluntary Accident

Accident Type: Off the Job Coverage

Policy Age Limit: 85

Individual Grace Period: 31 days

Disclosure of Services:
In addition to the insurance coverage, We may offer non-insurance benefits and services to Employees.

VOLUNTARY ACCIDENT BENEFITS

	Benefit Amount		
Description of Benefit	**Primary Insured**	**Spouse**	**Children**
Abdominal/Thoracic Surgery Benefit	$1,000	$1,000	$1,000
Accidental Death Benefit	$50,000	$25,000	$12,500
Accidental Death - Common Carrier Benefit	$150,000	$75,000	$37,500
Accidental Dismemberment Benefit			
• Both hands or both feet or sight of both eyes	$50,000	$25,000	$12,500
• One hand and One foot	$25,000	$12,500	$6,250
• Speech and hearing in both ears	$50,000	$25,000	$12,500
• Either hand or foot and sight of one eye	$50,000	$25,000	$12,500
• Either hand or foot	$25,000	$12,500	$6,250
• Sight of one eye	$25,000	$12,500	$6,250
• Speech or hearing in both ears	$25,000	$12,500	$6,250
• Thumb and index finger of either hand	$5,000	$2,500	$1,250
Accident Follow-Up Benefit	$75	$75	$75
Acupuncture Benefit	$25	$25	$25
Ambulance (Air) Benefit	$1,000	$1,000	$1,000
Ambulance (Ground) Benefit	$300	$300	$300
Arthroscopic Surgery Benefit	$300	$300	$300
Blood/Plasma/Platelet Benefit	$300	$300	$300
Burn Benefit			
• Third Degree Burns	$10,000	$10,000	$10,000
• Second Degree Burns	$1,000	$1,000	$1,000
Child Care Benefit	$25 per day	$25 per day	N/A
• Maximum Daily Amount	$100 per day	$100 per day	
Chiropractic Care Benefit	$25	$25	$25
Coma Benefit	$10,000	$10,000	$10,000
Concussion Benefit	$200	$200	$200
Daily Hospital Confinement Benefit	$200	$200	$200
• Lifetime Maximum	365 days	365 days	365 days

Description of Benefit	Benefit Amount Primary Insured	Spouse	Children
Daily ICU Confinement Benefit	$400 per day	$400 per day	$400 per day
Diagnostic Exam Benefit	$150	$150	$150
Dislocations Benefit (open reduction)			
• Hip	$3,800	$3,800	$3,800
• Knee (except patella)	$1,800	$1,800	$1,800
• Ankle – bone/bones of the foot (other than toes)	$1,400	$1,400	$1,400
• Collarbone (sternoclavicular)	$500	$500	$500
• Lower jaw	$640	$640	$640
• Shoulder (glenohumeral)	$1,400	$1,400	$1,400
• Elbow	$640	$640	$640
• Wrist	$1,400	$1,400	$1,400
• Bone/bones of the hand (other than fingers)	$640	$640	$640
• Collarbone (acromioclavicular and separation)	$320	$320	$320
• One toe or finger	$320	$320	$320
Dislocations Benefit (closed reduction)			
• Hip	$1,900	$1,900	$1,900
• Knee (except patella)	$900	$900	$900
• Ankle – bone/bones of the foot (other than toes)	$700	$700	$700
• Collarbone (sternoclavicular)	$250	$250	$250
• Lower jaw	$320	$320	$320
• Shoulder (glenohumeral)	$700	$700	$700
• Elbow	$320	$320	$320
• Wrist	$700	$700	$700
• Bone/bones of the hand (other than fingers)	$320	$320	$320
• Collarbone (acromioclavicular and separation)	$160	$160	$160
• One toe or finger	$160	$160	$160

	Benefit Amount		
Description of Benefit	**Primary Insured**	**Spouse**	**Children**
Dislocations Benefit (incomplete)	25% of the Dislocations Benefit (closed)	25% of the Dislocations Benefit (closed)	25% of the Dislocations Benefit (closed)
Emergency Dental Benefit (extraction)	$100	$100	$100
Emergency Dental Benefit (crown)	$300	$300	$300
Emergency Room Benefit	$200	$200	$200
Eye Injury Benefit surgical repair	$450	$450	$450
Eye Injury Benefit removal of foreign object	$150	$150	$150
Fractures Benefit (open reduction)			
• Skull (except bones of face or nose)			
○ Depressed skull fracture	$3,600	$3,600	$3,600
○ Simple non-depressed skull fracture	$1,000	$1,000	$1,000
• Hip, thigh (femur)	$4,000	$4,000	$4,000
• Vertebrae, body of (excluding vertebral processes)	$3,600	$3,600	$3,600
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	$3,600	$3,600	$3,600
• Leg (tibia and/or fibula)	$2,200	$2,200	$2,200
• Bones of face or nose (except mandible or maxilla)	$640	$640	$640
• Upper jaw, maxilla (except alveolar process)	$1,400	$1,400	$1,400
• Upper arm between elbow and shoulder (humerus)	$1,800	$1,800	$1,800
• Lower jaw, mandible (except alveolar process)	$1,400	$1,400	$1,400
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	$1,800	$1,800	$1,800
• Vertebral processes	$640	$640	$640
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	$1,800	$1,800	$1,800

Description of Benefit	Benefit Amount Primary Insured	Spouse	Children
• Kneecap (patella)	$1,800	$1,800	$1,800
• Foot (except toes)	$1,800	$1,800	$1,800
• Ankle	$1,800	$1,800	$1,800
• Rib	$500	$500	$500
• Coccyx	$500	$500	$500
• Finger, toe	$320	$320	$320
Fractures Benefit (closed reduction)			
• Skull (except bones of face or nose)			
○ Depressed skull fracture	$1,800	$1,800	$1,800
○ Simple non-depressed skull fracture	$500	$500	$500
• Hip, thigh (femur)	$2,000	$2,000	$2,000
• Vertebrae, body of (excluding vertebral processes)	$1,800	$1,800	$1,800
• Pelvis (includes ilium, ischium, pubis, acetabulum, and cetabulum except coccyx)	$1,800	$1,800	$1,800
• Leg (tibia and/or fibula)	$1,100	$1,100	$1,100
• Bones of face or nose (except mandible or maxilla)	$320	$320	$320
• Upper jaw, maxilla (except alveolar process)	$700	$700	$700
• Upper arm between elbow and shoulder (humerus)	$900	$900	$900
• Lower jaw, mandible (except alveolar process)	$700	$700	$700
• Shoulder blade (scapula) and/or collarbone (clavicle, sternum)	$900	$900	$900
• Vertebral processes	$320	$320	$320
• Forearm (radius and/or ulna), hand, and/or wrist (except fingers)	$900	$900	$900
• Kneecap (patella)	$900	$900	$900

	Benefit Amount		
Description of Benefit	**Primary Insured**	**Spouse**	**Children**
• Foot (except toes)	$900	$900	$900
• Ankle	$900	$900	$900
• Rib	$250	$250	$250
• Coccyx	$250	$250	$250
• Finger, toe	$160	$160	$160
Chip Fracture	25% of Fractures Benefit (closed reduction)	25% of Fractures Benefit (closed reduction)	25% of Fractures Benefit (closed reduction)
Home Health Care Benefit	$50 per day	$50 per day	$50 per day
Hospital Admission Benefit	$1,000	$1,000	$1,000
Initial Physician Visit Benefit	$75	$75	$75
Knee Cartilage Benefit (with repair)	$750	$750	$750
Knee Cartilage Benefit (without repair)	$150	$150	$150
Lacerations Benefit			
• 2” to 6” with sutures	$150	$150	$150
• Greater than 6” with suture	$300	$300	$300
Lodging Benefit	$125 per day	$125 per day	$125 per day
Medical Appliance Benefit	$150	$150	$150
Paralysis Benefit (Paraplegia)	$5,000	$5,000	$5,000
Paralysis Benefit (Quadriplegia)	$10,000	$10,000	$10,000
Physical Therapy Benefit	$50 per day	$50 per day	$50 per day
Prosthesis Benefit			
• Single	$750	$750	$750
• Two or more	$1,500	$1,500	$1,500
Rehabilitation Facility Benefit	$150 per day	$150 per day	$150 per day
Ruptured Disc Benefit	$750	$750	$750
Skin Graft Benefit	25% of Burn Benefit	25% of Burn Benefit	25% of Burn Benefit
Tendon/Ligament/Rotator Cuff Benefit			
• Single	$750	$750	$750
• Two or more	$1,000	$1,000	$1,000

	Benefit Amount		
Description of Benefit	**Primary Insured**	**Spouse**	**Children**
Transportation Benefit	$300	$300	$300
Urgent Care Benefit	$150	$150	$150
X-Ray Benefit	$150	$150	$150

DEFINITIONS

Accident means a sudden, unforeseeable event.

Actively at Work, Active Work means that an Employee is:

1) performing all the regular duties of his/her job for the Policyholder in the usual way for 30 or more hours each week; and
2) receiving compensation from the Policyholder for work performed.

An Employee is considered actively at work on any day that is not his/her regular scheduled workday (e.g., vacation or holiday) as long as the Employee was actively working on his/her last preceding regular scheduled workday.

Additional Enrollment Event means a period of time designated for enrollment under the Policy, other than an Annual Enrollment Period, as agreed to in writing by Our authorized representative in our Home Office.

Annual Enrollment Period means a period of time during which annual benefits enrollment occurs each year as determined by the Policyholder.

Certificate means this document, which explains the insurance benefits provided, to whom and how benefits are payable, and limitations and exclusions that apply to coverage.

Change in Family Status means one of the following events:

1) You get married or enter into a relationship with a person who satisfies the definition of Spouse;
2) You and Your Spouse divorce or legally terminate Your relationship;
3) Your Spouse dies;
4) You acquire a child who satisfies the definition of Dependent Child;
5) Your child no longer satisfies the definition of a Dependent Child or dies; or
6) Your Spouse is no longer employed, which results in a loss of accident insurance sponsored by the Spouse's employer for You or any Dependent(s).

Child Care Services means child supervision services which:

(a) is operated in a private home, school or other facility;
(b) provides, and makes a charge for, the care of children; and
(c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Child Care Services includes child care provided in the Primary Insured's or Spouse's home by a licensed child care provider, if such licensing is required by the state or jurisdiction in which it is located. If such licensing is not required, care in the home must be provided by an individual who offers professional child care services for a fee.

Child Care Services will not include child care which is provided by a Family Member of the child receiving the care.

Chip Fracture means a Covered Injury where small fragments of bone are chipped from the bones main structure. These are also known as avulsion fractures.

Coma means complete unconsciousness with inability to respond to external or internal stimuli for a continuous period of at least 168 hours. The diagnosis of a Coma must be made by a Physician. Coma includes a medically induced coma.

Common Carrier means commercial airplanes, helicopters, trains, buses, trolleys, subways, ferries and boats that operate on a regularly scheduled basis between predetermined points or cities. Taxis, privately chartered vehicles and the personal vehicles of a Covered Person are not Common Carriers.

Complications of Pregnancy means any condition, whether or not a pregnancy is terminated, that requires Hospital Confinement and whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Examples include: acute nephritis; cardiac decompensation; disease of the endocrine, hemopoietic, nervous or vascular systems; ectopic pregnancy that is terminated; hyperemesis gravidarum; missed abortion; nephrosis; non-elective caesarean section; spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or any similar condition(s) of comparable severity.

This definition does not include: elective caesarean section unrelated to a diagnosed complication of pregnancy; false labor; morning sickness; multiple gestation pregnancy; occasional spotting; physician prescribed rest during pregnancy; pre-eclampsia; any similar condition(s) associated with a difficult pregnancy but not considered a classifiable, distinct complication of pregnancy; or any other condition associated with pregnancy but has not been diagnosed by a Physician as a complication of pregnancy as defined.

Concussion means a traumatic brain injury resulting in immediate and transient alteration in brain function, including alteration of mental status and level of consciousness.

Confined or Confinement means being an Inpatient in a medical facility for a period of at least 1 day due to a Covered Injury sustained in a Covered Accident.

Confined Elsewhere means You are unable to perform, unaided, the normal functions of daily living, or leave home or other place of residence without assistance.

Continuation means coverage according to the provision under the Group Accident insurance plan where an eligible employee is currently enrolled, when the eligible employee is no longer Actively at Work.

Contributory Coverage means coverage for which You are required to contribute toward the cost.

Covered Accident means an Accident that

1) occurs while this Certificate is in force;
2) occurs while the Covered Person's insurance is effective; and
3) is not subject to any exclusion in the Policy.

Covered Injury means an Injury sustained by a Covered Person that is proximately caused by a Covered Accident, and which is not proximately caused by disease or bodily infirmity.

Covered Person means the Employee and any Dependent(s) who is/are currently insured under the Policy and this Certificate.

Day Care or Day Care Program means a program of child care which:

(a) is operated in a private home, school or other facility;
(b) provides, and makes a charge for, the care of children; and
(c) is licensed as a day care center or is operated by a licensed day care provider, if such licensing is required by the state or jurisdiction in which it is located or, if licensing is not required, provides childcare on a daily basis for 12 months a year.

Day Care does not include care which is provided by a Family Member of the child receiving the care.

Dependent, Dependents means an Employee's Spouse and Dependent Child(ren).

Dependent Child(ren) means:

1) an Employee's or Spouse's natural child, legally adopted child or stepchild;
2) a child placed into the Employee's or Spouse's custody for adoption (regardless of whether the adoption has become final);

3) a child for whom the Employee or Spouse is ordered by a court or administrative order to provide coverage regardless of whether he/she is the custodial or non-custodial parent; or any other child for whom the Employee or Spouse has been appointed legal guardian; who is/are under 26 years of age.

If a child is age 26 or older and is:
(a) incapable of self-sustaining employment because of a mental or physical disability;
(b) chiefly dependent on the Employee or Spouse for financial support and maintenance; and proof has been provided of his/her disability upon Our request, that child will continue to be a dependent child until these conditions cease to exist.

Disabled or Disability means the Covered Person:

(A) During the first 24 months of total disability is unable to perform with reasonable continuity the substantial and material duties of his or her job due to sickness or bodily injury.

(B) After the first 24 months of total disability, the insured, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, or physical and mental capacity.

Dislocation means a completely separated joint. An open reduction of a Dislocation means a Dislocation that requires one or more open surgical procedures for full repair. A closed reduction of a Dislocation means a Dislocation that is repaired with non-surgical or non-open surgical procedure(s).

Dismemberment means the total and irrevocable loss of any of the losses referenced in the Benefit Schedule.

Emergency Room (ER) means a specified area within a Hospital that is designated for emergency healthcare. This area must:
1) be staffed and equipped to handle trauma;
2) be under the direct supervision of a Physician;
3) provide Treatment by Physicians and/or Medical Professionals; and
4) provide care 24 hours per day, 7 days per week.

This definition does not include an Urgent Care Facility.

Employee means a person who:
1) is a citizen or legal resident of the United States (including its territories and protectorates); or
2) is lawfully and legally able to work in the United States pursuant to applicable law(s); and
3) works for the Policyholder on a regular basis in the usual course of the Policyholder's business.

This definition does not include a person working for the Policyholder:
1) on a temporary, leased or seasonal basis;
2) as an independent contractor (including persons for whom income is reported on a 1099 form);
3) subject to the terms of a leasing agreement between the Policyholder and a leasing organization; or
4) who resides outside the United States for a period in excess of 12 months, unless written approval has been received from Us.

Extended Care Facility means a place which:
(a) is licensed by the state in which it is located;
(b) provides nursing home care on an inpatient basis under the supervision of a Physician;
(c) has nursing services provided by or under the supervision of a registered nurse (RN), licensed vocational nurse (LVN), or licensed practical nurse (LPN);
(d) keeps a daily medical record of each patient; and
is either a freestanding facility or a ward, wing, or swing bed of a Hospital or other institution.

Extended Continuation means coverage according to the provision under the Group Accident insurance plan where an eligible employee is currently enrolled, when the eligible employee's status would activate the Termination of Coverage provision.

Family Member means a Covered Person's Spouse (current and former); domestic partner (or equivalent); child; sibling; parent; grandparent; grandchild; aunt; uncle; first cousin; nephew; niece; or the spouse or domestic partner (or equivalent) of such individuals. This includes adopted, in-law and step-relatives, and anyone living in the Covered Person's household.

Fracture means a broken bone which can be seen by x-ray. An open reduction of a Fracture means a Fracture that requires one or more open surgical procedures for full repair. A closed reduction of a Fracture means a Fracture that is repaired with non-surgical or non-open surgical procedure(s).

Follow-Up Treatment means consultation, care or services provided by a Physician for Injuries incurred from a Covered Accident. Follow-Up Treatment must occur after initial treatment by a Physician or in an Emergency Room for Injuries due to the same Accident.

Home Health Care means the provision of continued care and treatment of a Covered Person in the home if:

(a) The institutionalization of the Covered Person in a Hospital or related institution or skilled nursing facility would otherwise have been required if Home Health Care were not provided; and
(b) The plan of treatment covering the Home Health Care service is established and approved in writing by a Physician.

Home Office means Our office at 21555 Oxnard Street, Woodland Hills, CA 91367.

Hospital means an institution:

(a) licensed to operate as a Hospital pursuant to law;
(b) primarily and continuously engaged in providing or operating either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and
(c) providing twenty-four hour nursing service by or under the supervision of registered nurses.

Hospital does not include:

(a) convalescent homes, or convalescent, rest or nursing facilities;
(b) facilities affording primarily custodial, educational or rehabilitory care; or
(c) facilities for the aged, drug addicts or alcoholics.

Illness means a physical or mental condition, disease, disorder, illness or infection, including normal pregnancy and childbirth and Complications of Pregnancy, that is not caused solely by nor is the result of a Covered Accident. This definition includes organ donation and quarantine in a Hospital due to an identifiable exposure to a life-threatening contagious and/or infectious disease.

Incomplete Dislocation means a dislocation in which the joint is not completely separated.

Individual Grace Period means a grace period of 31 days that will be granted for receipt of the payment for each premium falling due after the first premium. During the grace period the Certificate shall continue in force subject to the Termination of Insurance provision.

Injury or Injuries means physical harm or damage.

Inpatient means treatment received by the Covered Person as a resident patient using and being charged for the room and board facilities of a Hospital.

Intensive Care Unit (ICU) means a specifically designated part of a Hospital called an intensive care unit as listed in the most current American Hospital Association Guide that:

(a) provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
(b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
(c) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
(d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24 hour basis; and
(e) has an assigned Physician on a full-time basis.

An Intensive Care Unit includes a neonatal intensive care unit specializing in the care of ill or premature newborn infants. An Intensive Care Unit is not any of the following step-down units:
(a) a progressive care unit;
(b) an intermediate care unit;
(c) a private monitored room;
(d) sub-acute intensive care unit; or
(e) an Observation Unit.

Laceration means a cut of at least 2 inches in length requiring sutures.

Medical Appliance means a walking boot that extends above the ankle, brace for the neck, back, knee or leg, cane, crutches, walker and wheelchair.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following Outpatient surgery or treatment in the Emergency Room by a Physician and which:
(a) is under the direct supervision of a Physician or registered nurse;
(b) is staffed by nurses assigned specifically to that unit; and
(c) provides care seven days per week, 24 hours per day.

Off the Job Coverage means coverage is provided under the Policy for Injuries resulting from a Covered Accident that occurs while the Covered Person is not working for pay or profit.

On the Job Coverage means coverage is provided under the Policy for only for Injuries resulting from a Covered Accident that occurs while the Covered Person is working for pay or profit.

Outpatient means treatment received by the Covered Person at a Hospital or licensed ambulatory care facility and there is no charge for room and board.

Paralysis means a Covered Injury to the brain or spinal cord that results in loss of use or loss of movement of multiple limbs (arms and/or legs).

Paraplegia means the complete and irreversible Paralysis of both legs.

Physician means a person who is:
1) a doctor of medicine, osteopathy, psychology or where required by state law, any other legally qualified practitioner of healing art;
2) licensed to practice in the jurisdiction where care is being given;
3) operating within the scope of his or her license; and
4) not the Covered Person or a Family Member.

Policy means the policy that We issued to the Policyholder under the Policy Number shown on the face page.

Policyholder means the Employer.

Primary Insured means an Employee who is currently insured under the Policy and this Certificate. (See also You, Yours.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

Prior Policy means any similar insurance policy or plan:

1) replaced by insurance under part or all of the Policy; and
2) in effect and maintained or sponsored by the Policyholder or an employer acquired by the Policyholder on the day before the Policy Effective Date.

Quadriplegia means the complete and irreversible Paralysis of both arms and both legs.

Rehabilitation Unit means an appropriately licensed facility that provides rehabilitation care services on an inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational and vocational services to enable patients Disabled by a Covered Accidental Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians. The rehabilitation unit may be part of a Hospital or a freestanding facility.
A rehabilitation unit is not:

(a) a nursing home;
(b) an Extended Care Facility;
(c) a skilled nursing facility;
(d) a rest home or home for the aged;
(e) a hospice care facility;
(f) a place for alcoholics or drug addicts; or
(g) an assisted living facility.

Second Degree Burn means a burn in which damage penetrates into some of the underlying layers of skin.

Sound, Natural Tooth means a tooth that is stable, functional, free from decay and advanced periodontal disease, and in good repair at the time of the accident, as determined by a dental professional, or by evidenced by a dental examination within 2 calendar years of the accident.

Spouse means any individual who, under applicable state law is recognized as a Spouse.

Spouse also includes any individual who is a partner to a civil union, a registered domestic partnership with a government agency or office where such registration is available, or other relationship allowed by state law.

For residents of states that do not offer domestic partner registration: Spouse will include Your affidavit domestic partner provided You have executed a complete domestic partner affidavit, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered affidavit domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

Spouse does not include any person who is insured as an employee.

Third Degree Burn means a burn which extends to all layers of skin.

Urgent Care Facility means is a facility or place other than a Physician's office, Hospital, or an Emergency Room that provides emergency or urgent care and treatment to Injured people. Such facility may be a 24-hour clinic.

We, Us, Our means Anthem Blue Cross Life and Health Insurance Company.

You, Yours means an Employee who is currently insured under the Policy and this Certificate. (See also Primary Insured.) This definition also includes a Spouse who has elected to continue coverage under the Extended Continuation provision.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility for Coverage

An Employee will become eligible for coverage under the Policy on the latest of:

1) the Policy Effective Date; or
2) the date he/she becomes a member of an Eligible Class.

A Dependent will become eligible for coverage under the Policy on the later of:

1) the date the Employee becomes insured under the Policy; or
2) the date You acquire the Dependent.

If more than one person within an immediate family unit is eligible for coverage under the Policy as an Employee of the Policyholder, then:

1) neither Employee may be covered as a Dependent of the other person; and
2) Dependent Child(ren) may only be covered as a Dependent of one Employee.

The date on which an Employee or Dependent becomes eligible for coverage may not be the same date on which insurance begins. The Coverage Effective Date provision describes the date on which insurance begins.

Initial Enrollment

An Employee must enroll for coverage for the Employee and any Dependent(s) within 31 days following the day the Employee or Dependent(s) first become(s) eligible for coverage under the Policy.

If an Employee does not elect coverage during the Employee's or Dependent's initial enrollment period, future enrollment may only occur as provided in the Changes in Coverage provision.

Coverage Effective Date

Coverage will start on the latest to occur of:

1) the date an Employee or Dependent becomes eligible as described in the Eligibility for Coverage provision, if enrolled on or before that date;
2) the Policy Anniversary following the last day of an Annual Enrollment Period, if an Employee or Dependent is enrolled during an Annual Enrollment Period;
3) the first day of the month following the last day of an Additional Enrollment Event, if an Employee or Dependent is enrolled during an Additional Enrollment Event; or
4) the date an Employee or Dependent is enrolled.

In no event will Dependent insurance become effective before an Employee becomes insured.

The Coverage Effective Date for any Employee or Dependent is subject to the Deferred Coverage Effective Date provision.

Deferred Coverage Effective Date

All Coverage Effective Dates and Changes in Coverage effective dates for an Employee will be deferred if an Employee is not Actively at Work on the day coverage would otherwise begin. If deferred, coverage will become effective on the day after the date the Employee has completed one full day of Active Work.

In no event will Dependent insurance become effective before an Employee becomes insured.

This provision does not apply to Employees who are currently eligible for coverage under the Continuity from a Prior Policy provision.

Continuity from a Prior Policy
Coverage under the Policy will begin and will not be deferred if, on the day before the Policy Effective Date, an Employee:

1) was insured under a Prior Policy; and
2) is otherwise eligible under the Policy but is not Actively at Work on the Policy Effective Date and:
   a) is on a leave of absence protected under:
      i. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA); or
      ii. any other applicable federal or state law that allows for continuation of insurance in certain instances; or
   b) was eligible for and insured under a continuation provision of a Prior Policy on the day before the Policy Effective Date; provided the Employee is not insured under any continuation or conversion provision of a Prior Policy after the Policy Effective Date.

If coverage is continued for an Employee under this provision, coverage may also be continued for any eligible Dependent(s) who were insured under the Prior Policy. Insurance under this provision is subject to uninterrupted payment of premium to Us when due.

Coverage provided through this provision ends on the first to occur of:

1) the last day of the 12th month on or next following the Policy Effective Date;
2) the last day the Employee would have been covered under the Prior Policy, had the Prior Policy not terminated;
3) the last day of the continuation period allowed by FMLA, USERRA or applicable federal or state law;
4) the date insurance terminates for any reason shown under the Termination of Coverage provision; or
5) the date the Employee resumes Active Work for the Policyholder or begins full-time employment with any other employer.

If an Employee is eligible for insurance under this provision, the Employee is not eligible for insurance under any Continuation or Extension of Coverage provision of this Certificate. Except as stated in this provision, coverage under this provision is subject to all other terms and provisions of the Policy.

Changes in Coverage
An Employee may elect, drop, increase, decrease or otherwise change coverage only:

1) during an Annual Enrollment Period or any Additional Enrollment Event; or
2) within 31 days of a Change in Family Status.

Any change in coverage requested by an Employee will become effective on:

1) the Policy Anniversary following the last day of an Annual Enrollment Period, if the change is requested during such period;
2) the first day of the month following the last day of an Additional Enrollment Event, if the change is requested during such event; or
3) the date on which the change is requested following a Change in Family Status; subject to the Deferred Effective Date provision.

Any change in coverage requested by the Policyholder or as a result of a change in the terms of the Policy will become effective on the first day of the month following the date of the request or change.

TERMINATION OF COVERAGE

Termination of Coverage

Coverage for You and any Dependent(s) will end on the earliest of the following:

1) the date You become no longer eligible for insurance under any provision of the Policy;
2) the date You attain age 85;
3) the date You are no longer in an Eligible Class or the Policy no longer covers Your class;
4) the date You request We terminate coverage, subject to the Changes in Coverage provision;
5) the date the required premium is due but not paid, or
6) the date the Policy terminates.

Coverage for a Dependent will also end on the last day of the month during which a Dependent no longer satisfies the definition of Spouse or Dependent Child(ren), except for a Dependent Child that reaches the limiting age. Coverage for a Dependent Child that reaches the limiting age will end the last day of the month the child attains the limiting age.

When coverage would otherwise end, You or an insured Spouse, in certain circumstances may be able to continue insurance for You and any Dependent Child(ren):

1) under the Policy provision labeled “Continuation”; or
2) under the Policy provision labeled “Extended Continuation”.

Termination of coverage has no effect on benefits payable for treatment that is received for a Covered Injury sustained while a Covered Person was insured under the Policy.

CONTINUATION

Continuation
You may be able to continue coverage for You and any Dependent(s) in certain circumstances when You are no longer Actively at Work. The Continuation Options are explained below.

Any coverage continued under this provision through any of the Continuation Option(s) is subject to the following conditions:

1) We must continue to receive premium payment when due (premiums must be paid by You or paid on Your behalf);
2) the Policyholder must approve the continuation; and
3) if You are eligible for more than one Continuation Option:
   a) the continuation time periods will not be applied consecutively; and
   b) the longest applicable continuation time period from the date You were last Actively at Work will apply.

Coverage continued under this provision will end on the earliest of the day:

1) the applicable continuation time period has expired, as described in the Continuation Options;
2) You return to Active Work for the Policyholder; or
3) You begin full-time employment with an employer other than the Policyholder.

Coverage continued under this provision will also end in accordance with the Termination of Coverage provision. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

Continuation Option(s)
Leave of Absence: If You are on a leave of absence approved by the Policyholder due to any personal reason, coverage may be continued for up to 12 weeks from the date You ceased Active Work.

Federal and/or State Laws: The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain circumstances for medical leaves of absence, military leaves of absence, other leaves of absence, layoff or termination of employment.

If You are not Actively at Work and are eligible to continue insurance under one of these laws, coverage may be continued for up to the time period allowed by the law that enables the continuation. Contact the Policyholder for additional information regarding continuation options that may be available through federal and/or state laws.

Illness or Injury: If You are not Actively at Work due to Illness or Injury, coverage may be continued for up to 12 weeks from the date You ceased Active Work.

Temporary Layoff: If You are subject to a temporary involuntary layoff by the Policyholder, coverage may be continued for up to 12 weeks from the date You ceased Active Work. If the layoff becomes permanent, this continuation will cease immediately.

Furlough: If You are subject to a temporary work furlough by the Policyholder, coverage may be continued for up to 12 weeks from the date You ceased Active Work. If the furlough ends or becomes permanent (employment is terminated), this continuation will cease immediately.

EXTENDED CONTINUATION

Extended Continuation
You or an insured Spouse, in certain circumstances, may continue coverage under the Policy when insurance would otherwise end under the Termination of Coverage provision.

If You are age 84 or younger, You may be able to continue coverage for You and any insured Dependent(s) under this provision when You:

1) are no longer Actively at Work and are not eligible for coverage under any other Continuation provision in this Certificate; or
2) are no longer employed by the Policyholder, including retirement.

If You are eligible to continue coverage under this provision, then You must elect insurance under this provision in order for any Dependent(s) to remain eligible for coverage.

An insured Spouse who is age 84 or younger may be able to continue coverage under this provision for him/herself and any insured Dependent Child(ren):

1) in the event of Your death;
2) in the event of divorce, dissolution of partnership or legal separation from You; or
3) when You enter active duty service or training in any military for a period of 31 days or more and are no longer eligible under the Policy as an Employee.

If an insured Spouse continues coverage under this provision, the Spouse will become a Primary Insured going forward. Any Dependent Child(ren) may be covered under the Employee or the Spouse, but not both.

Requesting Extended Continuation
When coverage under the Policy would otherwise end, notice of the right to continue coverage under this provision will be given. To elect Extended Continuation, You or Your insured Spouse must send a request to Us.

The request and the initial premium due must be received within 31 days after insurance under the Policy would otherwise end. If timely notice is not given, an extension of the period of time in which to request continued coverage under this provision will be allowed. You or Your Spouse will have 15 days from the date notice is received to submit the request and initial premium. However, in no event will a request be processed if received more than 91 days after the date coverage under the Policy would otherwise end, even if notice is not received.

Coverage continued under this provision:

1) will become effective on the first day of the month following the date coverage under the Policy would otherwise end, so that there is no interruption in coverage; and
2) is subject to continued payment of premium as due, including any portion of the premium that was previously paid for by the Policyholder.

Coverage continued under this provision will end on the last day of the month during which You resume Active Work for the Policyholder.

Coverage continued under this provision will also end in accordance with the Termination of Coverage provision. Except as described in this provision, coverage continued under this provision is subject to all other terms and provisions of the Policy.

VOLUNTARY ACCIDENT BENEFITS

Abdominal/Thoracic Surgery Benefit. We will pay the Abdominal/Thoracic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Injury sustained in a Covered Accident, a

Covered Person undergoes open abdominal or thoracic surgery to repair internal Injuries. The surgery must occur within 90 days of the Covered Accident to repair the Covered Injury. Hernia repair is not covered under this benefit. Only one Abdominal/Thoracic Surgery Benefit is payable per Covered Accident per Covered Person. Either the Abdominal/Thoracic Surgery Benefit or the Arthroscopic Surgery Benefit is payable for the same Covered Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Accident Follow-Up Benefit. We will pay the Covered Accident Follow-Up Benefit Amount shown in the Benefit Schedule for each day a Covered Person receives Follow-Up Treatment for Injuries sustained in a Covered Accident. Treatment must be recommended or advised by a Physician. Follow-Up Treatment must be received within 90 days of the Covered Accident. Follow-Up Treatment does not include routine examinations or preventative testing.

Accidental Death Benefit. If a Covered Person dies, and is proximately caused by a Covered Injury sustained in a Covered Accident, We will pay the Accidental Death Benefit Amount shown in the Benefit Schedule. Death must occur within 90 days of the Covered Accident. This benefit is not payable if We pay the Accidental Death – Common Carrier Benefit for the same Covered Person.

Accidental Death – Common Carrier Benefit. If a Covered Person dies, and is proximately caused by a Covered Injury sustained in a Covered Accident while a fare paying passenger on a Common Carrier, We will pay the Accidental Death – Common Carrier Benefit Amount shown in the Benefit Schedule. Death must occur within 90 days of the Covered Accident. This benefit is not payable if We pay the Accidental Death Benefit for the same Covered Person.

Accidental Dismemberment Benefit. If a Covered Person is dismembered, and is proximately caused by a Covered Injury sustained in a Covered Accident, We will pay the applicable Accidental Dismemberment Benefit Amount shown in the Benefit Schedule. Dismemberment must occur within 90 days of the Covered Accident.

Acupuncture Benefit. We will pay the Acupuncture Benefit Amount shown in the Benefit Schedule if a Covered Person receives acupuncture services for treatment of a Covered Injury sustained in a Covered Accident. Acupuncture must be provided by a practitioner licensed as required in the state where care is provided. Acupuncture must begin within 30 days after the date of the Covered Accident and be completed within one year of the date of Covered Accident. No more than 10 Acupuncture Benefits are payable per Covered Accident per Covered Person regardless of the number of acupuncture treatments received.

Ambulance (Air) Benefit. We will pay the Ambulance (Air) Benefit Amount shown in the Benefit Schedule for a licensed professional air ambulance company to transport a Covered Person to or from a Hospital, or between medical facilities for treatment of Injuries received in a Covered Accident. The air ambulance must provide the transportation services to the Covered Person within 72 hours after the date of the Covered Accident. One Ambulance (Air) Benefit is payable per Covered Accident per Covered Person.

Ambulance (Ground) Benefit. We will pay the Ambulance (Ground) Benefit Amount shown in the Benefit Schedule for a licensed professional ambulance company to transport a Covered Person by ground, to or from a Hospital or between medical facilities for treatment of Injuries received in a Covered Accident. The ambulance must provide transportation services to the Covered Person within 90 days after the date of the Covered Accident. One Ambulance (Ground) Benefit is payable per Covered Accident per Covered Person.

Arthroscopic Surgery Benefit. We will pay the Arthroscopic Surgery Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person undergoes arthroscopic surgery. The surgery must occur within 90 days of the Covered Accident to repair a Covered Injury sustained in the Covered Accident. Hernia repair is not covered under this benefit. Only one Arthroscopic Surgery Benefit is payable per Covered Accident per Covered Person. We will pay either the Arthroscopic Surgery Benefit or the greater of the following benefits for the same Covered Accident:

(a) Knee Cartilage Benefit;
(b) Ruptured Disc Benefit;
(c) Abdominal/Thoracic Surgery Benefit; or
(d) Tendon/Ligament/Rotator Cuff Benefit.

Blood/Plasma/Platelet Benefit. We will pay the Blood/Plasma/Platelet Benefit Amount shown in the Benefit Schedule if, due to a Covered Injury sustained in a Covered Accident, a Covered Person requires a transfusion, administration, cross matching, typing and processing of blood, plasma or platelets. The blood, plasma or platelet transfusion must be administered within 90 days of the Covered Accident. Only one Blood/Plasma/Platelet Benefit is payable per Covered Accident per Covered Person**.**

Burn Benefit. We will pay the Burn Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Injury sustained in a Covered Accident, a Covered Person sustains either:

(a) Third Degree Burns covering at least 18 square inches of the Covered Person's body; or
(b) Second Degree Burns covering at least 34% of the Covered Person's body. The Covered Person must be treated by a Physician within 72 hours after the date of the Covered Accident. Only one Burn Benefit is payable per Covered Accident per Covered Person, however if burns are in multiple degrees, then the highest benefit will be paid.

Child Care Benefit. We will pay the Child Care Benefit Amount shown in the Benefit Schedule if the Primary Insured or Spouse is confined in a Hospital due to a Covered Accident and requires Child Care Services for children under age 16. The Benefit Amount is available for each child receiving care and shall not exceed the Maximum Daily Amount shown in the Benefit Schedule. No more than 30 days of Child Care Services are payable per Covered Accident regardless of the number of days child care is needed. We must receive written proof that the Dependent Child is enrolled with a Day Care or Day Care Program, as defined in this Certificate.

Chiropractic Care Benefit. We will pay the Chiropractic Care Benefit Amount shown in the Benefit Schedule if a Covered Person receives chiropractic treatment for a Covered Injury sustained in a Covered Accident. The chiropractor must be licensed if required in the state where care is provided. Chiropractic Care must begin within 30 days after the date of the Covered Accident and be completed within one year of the date of Covered Accident. No more than 10 Chiropractic Care Benefits are available payable per Covered Accident per Covered Person regardless of the number of chiropractic treatments received.

Coma Benefit. We will pay the Coma Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person is diagnosed with a Coma. The Coma must be diagnosed or treated by a Physician within 90 days of the Covered Accident. Only one Coma Benefit is payable per Covered Accident per Covered Person.

Concussion Benefit. We will pay the Concussion Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person is diagnosed with a Concussion. The Concussion must

be diagnosed or treated by a Physician within 72 hours of Covered Accident. No more than 3 Concussions will be covered per year per Covered Person.

Daily Hospital Confinement Benefit. We will pay the Daily Hospital Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person was Confined in a Hospital due to an Injury received in a Covered Accident. Confinement must begin within 90 days of the Covered Accident and last at least 20 hours. The Daily Hospital Confinement Benefit is subject to a lifetime maximum of 365 days per Covered Person. This maximum includes all days a Covered Person is Confined in a Hospital, including days in an Intensive Care Unit of a Hospital. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Covered Accident. The Daily Hospital Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily Hospital Confinement Benefit and the Daily Intensive Care Unit Confinement Benefit concurrently for the same Covered Person. We will also not pay this Daily Hospital Confinement Benefit and the Rehabilitation Facility Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Daily ICU Confinement Benefit. Unless the Covered Person has reached his or her lifetime maximum Daily Hospital Confinement Benefits, We will pay the Daily ICU Confinement Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in an Intensive Care Unit due to a Covered Injury received within 30 days of a Covered Accident. If a Covered Person is Confined in an ICU for more than 30 days, the Daily Hospital Confinement Benefit will begin on the 31st day, provided the Covered Person has not reached his or lifetime maximum for Daily Hospital Confinement benefits. We will pay benefits for only one period of Confinement at a time even if it is caused by more than one Covered Accident. The Daily ICU Confinement Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit. We will not pay this Daily ICU Confinement Benefit and the Daily Hospital Confinement Benefit concurrently for the same Covered Person.

Diagnostic Exam Benefit. We will pay the Diagnostic Exam Benefit Amount shown in the Benefit Schedule if a Covered Person requires one of the following diagnostic examinations to determine the extent of a Covered Injury sustained in a Covered Accident:

(a) Computerized Axial Tomography (CAT);
(b) Computed Tomography (CT);
(c) Magnetic Resonance Imagings (MRIs); or
(d) Electroencephalogram (EEG).

The diagnostic exam must be scheduled within 90 days after the date of the Covered Accident. Only 1 Diagnostic Exam Benefit Amount is payable per Covered Accident per Covered Person regardless of the number of diagnostic examinations received.

Dislocations Benefit (open reduction, closed reduction and incomplete). If a Covered Person sustains a Dislocation as a result of a Covered Accident, We will pay the applicable Dislocation Benefit Amount shown in the Benefit Schedule.

The Dislocation must be diagnosed by a Physician within 90 days of the Covered Accident and corrected via an open (surgical) or closed (non-surgical) reduction under anesthesia by a Physician.

If a Physician diagnoses the Dislocation as incomplete (the joint is not completely separated), or the Dislocation requires treatment without anesthesia by a Physician, We will pay 25% of the Dislocation Benefit shown in the Benefit Schedule for a closed reduction a Dislocation for that joint.

If a Covered Person sustains multiple Fractures and Dislocations due to the same Covered Accident, We will pay both benefits. However, We will pay no more than two times the amount for the bone or joint involved that has the highest benefit amount.

This benefit is payable once per joint, per Covered Person. Further Dislocations of the same joint will not be covered under the Policy after a Dislocation Benefit has already been paid for that joint.

Emergency Dental Benefit (extraction and crown). We will pay the Emergency Dental Benefit Amount shown in the Benefit Schedule if a Covered Person requires the following dental work as a result of a Covered Injury sustained in a Covered Accident:

(a) repair of a broken Sound, Natural Tooth with a crown; or
(b) extraction of a broken Sound, Natural Tooth.

The dental work must occur within 90 days after the Covered Accident. Only one Emergency Dental Benefit Amount is payable per Covered Accident per Covered Person regardless of the number of teeth involved.

Emergency Room Benefit. We will pay the Emergency Room Benefit Amount shown in the Benefit Schedule if a Covered Person requires examination and treatment by a Physician in an Emergency Room as proximately caused by a Covered Injury sustained in a Covered Accident. The Emergency Room examination and treatment must occur within 72 hours after the date of the Covered Accident. No more than 1 Emergency Room Benefits will be payable per Covered Accident per Covered Person.

Eye Injury Benefit (removal or foreign object and surgical repair). We will pay the Eye Injury Benefit Amount shown in the Benefit Schedule if a Covered Person sustains a Covered Injury sustained in a Covered Accident to the eye. The Covered Injury must require surgery or removal of a foreign object by a Physician within 90 days of the Covered Accident. Only one Eye Injury Benefit is payable per Covered Accident per Covered Person.

Fractures Benefit (open reduction, closed reduction and Chip Fractures). We will pay the applicable Fractures Benefit Amount shown in the Benefit Schedule for a Fracture sustained in a Covered Accident. If a Covered Person sustains more than one Fracture due to the same Covered Accident, we will pay the benefits for all Fractures, up to a maximum of two times the amount shown in the Benefit Schedule for the bone involved with the highest benefit amount.

If the Covered Person is diagnosed by a Physician as having a Chip Fracture, we will pay 25% of the benefit shown in the Benefit Schedule for a closed reduction of the bone.

If a Covered Person sustains multiple Fractures and Dislocations due to the same Accident, we will pay both benefits. We will pay no more than two times the amount for the bone or joint involved, which has the highest benefit amount.

The Fracture must be diagnosed by a Physician within 90 days of the Covered Accident and must require open (surgical) reduction or closed (non-surgical) reduction by a Physician.

Home Health Care Benefit. We will pay the Home Health Care Benefit Amount shown in the Benefit Schedule for each day a Covered Person receives Home Health Care as a result of a Covered Accident. The Home Health Care Benefit is payable for the lesser of 30 days or the number of days the Covered Person is receiving Home Health Care. The Home Health Care Benefit is payable in addition to the Daily Hospital Confinement Benefit or the Daily ICU Confinement Benefit.

Hospital Admission Benefit. We will pay the Hospital Admission Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Injury received in a Covered Accident, a Covered Person is admitted to a Hospital. Admission to the Hospital must occur within 90 days of the Covered Accident. The total of all Hospital Admission Benefits for a Covered Person in a calendar year shall not exceed the Annual Maximum regardless of the number of admissions within that year. The Hospital Admission Benefit is not payable for Emergency Room treatment, Outpatient treatment, or a stay of less than 20 hours in an Observational Unit.

Initial Physician's Visit Benefit. We will pay the Initial Physician's Visit Benefit Amount if a Covered Person receives initial treatment by a Physician in a Physician's office as the result of a Covered Injury sustained in a Covered Accident. The treatment must be given within 90 days after the Covered Accident. Services for routine examinations or preventative testing are not included in this benefit. Only one Initial Physician's Visit Benefit is payable per Covered Accident per Covered Person.

Knee Cartilage Benefit (with and without repair). We will pay the applicable Knee Cartilage Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person sustains a torn knee cartilage (meniscus). Treatment must be first provided by a Physician within 60 days of the Covered Accident. If surgery is required, the Covered Person must undergo surgery within 12 months of the Covered Accident. Only one Knee Cartilage Benefit is payable per Covered Accident per Covered Person. Either the Knee Cartilage Benefit or the Arthroscopic Surgery Benefit is payable for the same Covered Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Lacerations Benefit. We will pay the Lacerations Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person sustains a Laceration. The Laceration must be repaired by a Physician within 72 hours of the Covered Accident. The benefit payable will be based on the total length of all Lacerations received in any one Accident which requires repair. Only one Lacerations Benefit is payable per Covered Accident per Covered Person. If a Covered Person sustains a Laceration that later results in loss or Dismemberment, We will subtract the amount paid under the Lacerations Benefit from the Accidental Dismemberment Benefit.

Lodging Benefit. We will pay the Lodging Benefit Amount shown in the Benefit Schedule for a companion to accompany the Covered Person while the Covered Person is Confined in a Hospital due to a Covered Injury sustained in a Covered Accident. The Covered Person must be Confined in a Hospital located more than 100 miles from the Covered Person's residence. This benefit will be payable for one room if the companion incurs a charge for staying in a hotel or a motel while the Covered Person is Confined. This Lodging Benefit is subject to a lifetime maximum of 30 nights per Covered Person.

Medical Appliance Benefit. We will pay the Medical Appliance Benefit Amount shown in the Benefit Schedule if, due to a Covered Injury sustained in a Covered Accident, a Covered Person requires a Medical Appliance as an aid in personal locomotion or mobility. The Medical Appliance must be prescribed by a Physician. Use of the Medical Appliance must begin within 90 days of the Covered Accident. Only one Medical Appliance Benefit is payable per Accident per Covered Person**.**

Paralysis Benefit. We will pay the Paralysis Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Injury sustained in a Covered Accident, a Covered Person is paralyzed and sustains Paraplegia or Quadriplegia. The Paralysis must occur within 90 days of the Covered Accident, must have lasted at least 30 days, and must be expected to be permanent. Paralysis must be diagnosed by a Physician and based on evidence that the Injury sustained in the Covered Accident caused the Paralysis.

Physical Therapy Benefit. We will pay the Physical Therapy Benefit Amount shown in the Benefit Schedule for each day a Covered Person requires physical therapy treatment for a Covered Injury received in a Covered Accident. Physical therapy must begin within 90 days of the Covered Accident or within 90 days of the date a Physician prescribes physical therapy following surgery or other medical treatment for Injury sustained in a Covered Accident. The Physical Therapy Benefit is subject to a

maximum of 10 days per Covered Person per Accident. Physical therapy must be prescribed by a Physician and rendered by a licensed physical therapist in an office or Hospital on an Inpatient or Outpatient basis.

Prosthesis Benefit. We will pay the applicable Prosthesis Benefit Amount shown in the Benefit Schedule if, due to a Covered Injury in a Covered Accident, a Covered Person:

(a) loses a hand, foot, arm, leg, eye; and
(b) requires a prosthetic device, artificial limb or eye, as prescribed by a Physician.

The prosthetic device/artificial limb or eye must be received within one year after the date of the Covered Accident. This benefit is not payable for joint replacement such as an artificial hip or knee. Only one Prosthesis Benefit is payable per Accident per Covered Person.

Rehabilitation Facility Benefit. We will pay the Rehabilitation Facility Benefit Amount shown in the Benefit Schedule for each day a Covered Person is Confined in a Rehabilitation Unit for physical, occupational or speech therapy treatment for a Covered Injury received in a Covered Accident.

Confinement must begin within 90 days of the Covered Accident and be preceded by Confinement in a Hospital. The Rehabilitation Facility Benefit is subject to a lifetime maximum of 15 days per Covered Person. We will pay benefits for only one period of Rehabilitation Facility Confinement at a time even if it is caused by more than one Accident. We will not pay this Rehabilitation Facility Benefit and the Daily Hospital Confinement Benefit for the same day. If a Covered Person is Confined in both a Hospital and a Rehabilitation Facility on the same day, the higher benefit will be payable.

Ruptured Disc Benefit. We will pay the Ruptured Disc Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person sustains a ruptured or herniated disc in the spine that must be repaired through surgery. The Covered Person must receive treatment from a Physician for the ruptured or herniated disc within 60 days of the Covered Accident and surgery must be performed within one year of the Covered Accident. Only one Ruptured Disc Benefit is payable per Accident per Covered Person regardless of the number of surgeries needed. Either the Ruptured Disc Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Skin Graft Benefit. We will pay the Skin Graft Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person receives a skin graft for a third degree burn for which a benefit was received under the Burn Benefit. Only one Skin Graft Benefit is payable per Accident per Covered Person.

Tendon/Ligament/Rotator Cuff Benefit. We will pay the applicable Tendon/Ligament/Rotator Cuff Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person receives a torn, ruptured or severed tendon, ligament or rotator cuff. The Injury must be treated by a Physician within 90 days of the Covered Accident and be repaired by surgery within one year. Only one Tendon/Ligament/Rotator Cuff benefit is payable per Covered Accident per Covered Person. Either the Tendon/Ligament/Rotator Cuff Benefit or the Arthroscopic Surgery Benefit is payable for the same Accident if treatment occurs on the same date. The higher of the two benefits will be paid.

Transportation Benefit. We will pay the Transportation Benefit Amount shown in the Benefit Schedule if, as a result of a Covered Accident, a Covered Person must travel more than 100 miles from his or her residence to a receive special treatment or be Confined in a Hospital. Treatment must be prescribed by a Physician and not available locally. This benefit is payable for up to 3 round trips per Covered Person per Covered Accident. This benefit is not payable for transportation by ambulance (air or ground).

Urgent Care Benefit. We will pay an Urgent Care Facility Benefit if a Covered Person requires treatment or care in an Urgent Care Facility due to a Covered Injury sustained in a Covered Accident. The Treatment must occur within 72 hours after the date of the Covered Accident. No more than 1 Urgent Care Benefits will be payable per Accident per Covered Person.

X-Ray Benefit. We will pay the X-Ray Benefit Amount shown in the Benefit Schedule if a Covered Person requires an x-ray as a result of a Covered Injury sustained in a Covered Accident. The x-ray must be prescribed by a Physician and performed in Physician's office or Hospital on an Inpatient or Outpatient basis. The x-ray must be performed within 90 days after the date of the Covered Accident. Only one X-ray Benefit Amount is payable per Accident per Covered Person regardless of the number of x-rays received.

EXCLUSIONS

Exclusions. No benefits are payable under this Certificate under the following applicable exclusions:

1) Condition or loss caused or substantially contributed by occupation or employment for compensation, wage or profit, as determined by the California Workers' Compensation Appeals Board or equivalent.
2) Condition or loss caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane.
3) Condition or loss caused or substantially contributed to by war or an act of war whether declared or undeclared.
4) Condition or loss caused or substantially contributed to by committing or attempting to commit a felony.
5) Condition or loss caused or substantially contributed to by active participation in a riot, insurrection, or terrorist activity.
6) Condition or loss caused or substantially contributed to by voluntary intake of either:
    a. Any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions.
    b. Poison, gas, or fumes, unless they are proximately caused by an occupational accident.
7) Condition or loss in consequence of the insured being intoxicated, as defined by the jurisdiction where the condition or loss occurred.
8) Condition or loss caused or substantially contributed to by engaging in aviation, other than as a fare-paying passenger.

Benefits are not payable for loss due to a Covered Accident unless such Accident occurred while the Certificate is in force and while the Covered Person's insurance is effective. No benefits are payable for loss due to a Covered Accident that is subject to any exclusion in the Policy.

CLAIM PROVISIONS

Notice of Claim
Notice of claim may be given to Us within 20 days after the start of any loss covered by the Policy, or as soon as reasonably possible. Notice given by or on behalf of a Covered Person to Us, or to Our authorized agent, with information sufficient to identify the Covered Person, shall be notice to Us.

Failure to give notice within this time frame will not invalidate nor reduce any claim.

Claim Forms
When We receive Claim Notice, We will send claim forms to the claimant. If the claimant does not receive the forms within 15 days after Claim Notice is sent, the claimant shall be deemed to have complied with the requirements of sending Claim Proof of Loss upon submitting within time fixed in filing the Claim Proof of Loss.

Claim Proof of Loss
The claimant must send proof of loss to Us. This proof must be provided within 90 days after the date of the loss. If it is not reasonably possible to give proof in this time, proof must be provided as soon as reasonably possible. Proof of loss may not be given more than one year after the time proof is otherwise required, unless the claimant is legally incapacitated.

Physical Examinations and Autopsy
We, at our own expense, shall have the right and opportunity to have:
1) a Covered Person for whom a claim is made examined by a Physician or Medical Professional of Our choice during the pendency of a claim as often as reasonably required; and
2) an autopsy conducted for a Covered Person for whom a claim is made in case of death, where not prohibited by law.

Time of Payment of Claims
Benefits payable under the Policy will be paid immediately upon Our receipt of due Claim Proof of Loss. Any other accrued indemnities unpaid at the Covered Person's death may, at the option of Us, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Covered Person.

Payment of Claims
All benefits are payable to You. Any benefits unpaid at the time of Your death will be paid to:
1) Your designated beneficiary(ies); or if none, then to
2) Your estate.

You have the right to request that any benefits for the Ambulance - Air Benefit or Ambulance - Ground or Water Benefit be paid directly to the service provider. You must request such payment within 90 days of the date the transportation occurred.

Beneficiary Designation
In the event of Your death, You should designate one or more beneficiaries to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, plan administrator or the office/system where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Policy will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If spousal consent to the designation is not obtained, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Change of Beneficiary
The beneficiary may be changed at any time by You or Your assignee (if You assigned this insurance). To make a change, a request should be provided to the Policyholder, plan administrator or to the office/system

where beneficiary records for the Policy are kept. If it is not known where the records are kept, then the request may be provided to Us. When received by the Policyholder, plan administrator, office/system where beneficiary records for the Policy are kept or Us, the change will take effect as of the date the request is signed. The change will not apply to any payments or other action taken by Us before the request was received.

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary, unless the current beneficiary designation is irrevocable.

Claim Denial
If a claim for benefits is wholly or partly denied, the claimant will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to the Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4) provide an explanation of the review procedure.

Claim Appeal
On any claim, the claimant or his or her representative may appeal to Us for a full and fair review. To do so, the claimant:

1) must submit a written request for review within:
   a) 180 days of receipt of Claim Denial if the claim requires Us to make a determination of an Covered Injury or other loss; or
   b) 60 days of receipt of Claim Denial if the claim does not require Us to make a determination of a Covered Injury or other loss; and
2) may request copies of all documents, records, and other information relevant to the claim; and
3) may submit written comments, documents, records and other information relating to the claim.

We will respond in writing with Our final decision on the claim. If You are not satisfied with the decision, You have the right to contact the California Insurance Department to review your dispute.

Overpayment Recovery
We have the right to recover from You or the recipient of benefits any amount that is an overpayment. You or the recipient of benefits has the obligation to refund to Us any such amount.

If benefits are overpaid on any claim, You or the recipient of benefits must reimburse Us within 90 days.

If reimbursement is not made in a timely manner, We have the right to:

(a) recover such overpayments from:
   1) You;
   2) any other person to or for whom payment was made; or
   3) Your estate;
(b) reduce or offset against any future benefits payable to You or Your survivors until full reimbursement is made;
(c) refer the unpaid balance to a collection agency; and
(d) pursue and enforce all legal and equitable rights in court.

Consumer Affairs Disclosure

Department of Insurance

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

CALIFORNIA DEPARTMENT OF INSURANCE CONSUMER SERVICES DIVISION

300 South Spring St., South Tower Los Angeles, CA 90013
Toll-free phone number: 1-800-927-HELP (4357)
TDD Number: 1-800-482-4TDD (4833)
https://www.dca.ca.gov/consumers/index.shtml

Complaints

If you have a complaint about services from Anthem Blue Cross Life and Health or your health care provider, please contact us at:

Anthem Supplemental Insurance Benefit Department, PO Box 2076, Grapevine, TX 76099
888-828-2432

GENERAL PROVISIONS

Entire Contract
The Policy, the Policyholder's signed application, this Certificate and any riders, endorsements or other attached papers make up the entire contract of insurance between the Policyholder and Us. All statements made by the Policyholder and persons insured under the Policy will be deemed representations and not warranties. No statement will be used in any contest unless it is in writing, signed by the person making it and a copy of it is given to the person who made it, or, in the event of the death or incapacity of the Covered Person, to the Covered Person's beneficiary or personal representative.

Statements
All statements made by the Policyholder or any Covered Person are considered representations and not warranties. No statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person, his or her beneficiary or personal representative and is attached to this Certificate.

Time Limit on Certain Defenses
Absent a showing of intentional fraud, no statement concerning insurability made by any Covered Person shall be used to contest the validity of the insurance for which the statement was made after this Policy has been in force for three years. In order to be used, the statement must be in writing and signed by the person making the statement. However, We are not precluded at any time from asserting defenses based upon the person's ineligibility for coverage under this Policy, or upon other provisions in the Policy.

No claim for loss incurred or disability commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

Grace Period
A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during the Grace Period the Policy shall continue in force. If the entire premium is not paid by the end of the Grace Period, this Policy will terminate.

If the Policyholder gives Us written advance notice of an earlier cancellation date, the Policy will terminate on the earlier date; but no such termination will take effect during any period for which the required premium has been paid to us.

Legal Actions
No legal action may start:
1) until 60 days after Claim Proof of Loss has been given;
2) more than 3 years after the time proof of loss is required to be given; unless otherwise required by law in Your or the claimant's jurisdiction of residence.

Misstatement of Age
If the age of any Covered Person has been misstated:
1) the premium may be adjusted; and
2) the true facts will be used to determine if, and for what amount, coverage should have been in force.

Assignment
You have the right to absolutely assign Your rights and interest under the Policy including, but not limited to, the following:
(a) the right to make any contributions required to keep the insurance in force; and
(b) the right to name and change a beneficiary.

We will recognize any absolute assignment made by You under the Policy, provided:

(a) it is duly executed; and
(b) a copy is acknowledged and on file with Us.

We and the Policyholder assume no responsibility:

(a) for the validity or effect of any assignment; or
(b) to provide any assignee with notices which We may be obligated to provide to You.

You do not have the right to collaterally assign his/her rights and interest under the Policy.

Conformity with State and Federal Laws
Any provision of the Policy that is contrary to the law of the jurisdiction in which it is delivered or with any other applicable law is amended to meet the minimum requirements of the law.

Time Periods
Unless otherwise specifically stated, all time periods begin and end at 12:01 A.M., Standard Time at the place where the Policy is delivered.

Workers' Compensation
The Policy does not replace Workers' Compensation or affect any requirement for Workers' Compensation coverage.

Unpaid Premium
Upon the payment of a claim, any premium then due and unpaid may be deducted from the claim payment.

Eligibility Determination
We, and not Your Employer or plan administrator, have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine the Covered Person's eligibility for benefits for any claim the Covered Person or the Covered Person's estate make on the Policy. We will:

(a) obtain with the Covered Person's cooperation and authorization if required by law, only such information that is necessary to evaluate his/her claim and decide whether to accept or deny his/her claim for benefits. We may obtain this information from the Covered Person's Notice of Claim, submitted proofs of loss, statements, or other materials provided by the Covered Person or others on the Covered Person's behalf; or, at Our expense. We may obtain necessary information, or have the Covered Person physically examined when and as often as We may reasonably require while the claim is pending. In addition, and at the Covered Person's option and at his/her expense, the Covered Person may provide Us and We will consider any other information, including but not limited to, reports from a Physician or other expert of the Covered Person's choice. The Covered Person should provide Us with all information that he/she want Us to consider regarding his/her claim;
(b) as a part of Our routine operations, We will apply the terms of the Policy for making decisions, including decisions on eligibility, receipt of benefits and claims, or explaining policies, procedures and processes;
(c) if We approve the Covered Person's claim, We will review Our decision to approve his/her claim for benefits as often as is reasonably necessary to determine his/her continued eligibility for benefits;
(d) if We deny the Covered Person's claim, We will explain in writing to the Covered Person the basis for an adverse determination in accordance with the Policy as described in the provision entitled Claim Denial.

In the event We deny the Covered Person's claim for benefits, in whole or part, he/she can appeal the decision to Us. If the Covered Person chooses to appeal Our decision, the process he/she must follow is set forth in the Policy provision entitled Claim Appeal. If the Covered Person does not appeal the decision to Us, then the decision will be Our final decision.