HIPAA Plans

Health Insurance Portability and Accountability Act of 1996

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- *Estimate Your Cost:* Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
- *Zagat Health Surveys:* See what other patients have said about the doctors and hospitals you're considering. Add your own doctor recommendation, too!

Register at anthem.com and have a wealth of health information right at your fingertips.

Anthem Blue Cross HIPAA PPO Share 5000 and HIPAA PPO Share 7500

Anthem Blue Cross Life and Health Insurance Company
HIPAA ClearProtection Plus 1000 and HIPAA ClearProtection Plus 5000

Rates effective 6/1/13

HIPAA plans

Thank you for choosing Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company for your health care coverage needs.

Eligibility — In order to be eligible for an Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company HIPAA plan, you must:

- Have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan;
- Have elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available;
- Have lost coverage within the last 63 days (For reasons other than fraud or non-payment of premiums.)
- Not be eligible for coverage under a group health plan, Medi-Cal, or Medicare, and have no other medical health insurance coverage; and
- Live or work in the service area of the plan you're applying for.

Eligibility of family members/dependents — must be a permanent legal resident of California and one of the following:

- the applicant's spouse or qualified Domestic Partner who is not Medicare-eligible
- the applicant's children (under 26 years of age), or the children (under 26 years of age) of the enrolling applicant's spouse or qualified Domestic Partner
- the applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and chiefly dependent upon the applicant for support and maintenance

Checklist

Please follow these general guidelines to make sure your application is completed correctly. Applications may take up to 30 days to review from the date Anthem receives them. If complete information is not provided, the application may be returned to you, or we may try to call you to obtain the necessary information.

Please review the checklist before submitting your application.

☐ The completed application must be received by Anthem within 63 days of losing your prior group or COBRA coverage.

☐ Print clearly and complete the application in blue or black ink.

☐ If you make any changes while completing this form, be sure to initial and date those changes.

☐ The primary applicant, spouse/Domestic Partner, and any applicant 18 years or older if applicable, must sign and date the application.

☐ Enclose all certificates of creditable coverage from former group health plan(s) or health insurance company(s). Your coverage will be delayed if proof of creditable coverage is not provided.

The following lists the various situations and the certificates of creditable coverage or alternate documentation we require when submitting a HIPAA application.

The applicant needs to have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan. Either of the following will meet this requirement:

☐ Certificate of Creditable Coverage — This must reflect the applicant's last 18 months of continuous coverage and have an end date.

☐ A letter from the prior employer or insurance carrier reflecting their last 18 months of continuous coverage.

This letter needs to have a start and end date and must state the type of plan you were covered under.

The applicant has elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available. If COBRA was exhausted, we will need one of the following:

☐ COBRA Expiration/Termination Letter - This document is usually sent 30-90 days prior to the applicant's COBRA expiration and simply explains that their COBRA will be coming to an end on a specific date.

☐ A letter from the prior employer or insurance carrier indicating COBRA was exhausted. This letter also needs to list the specific end date.

If Cal-COBRA was offered, we will need:

☐ A letter from the applicant's prior employer or insurance carrier indicating Cal-COBRA was exhausted. This letter needs to list the specific end date.

If Cal-COBRA was not offered, we will need one of the following:

☐ A letter from the applicant's prior employer or insurance carrier indicating they are self-insured.

☐ A letter from the applicant's prior employer or insurance carrier indicating they do not have a contract in the state of California.

☐ A copy of an Anthem Blue Cross ID card.

Miscellaneous scenarios:

If the applicant's prior group coverage ended and COBRA/Cal-COBRA was not offered, we will need:

☐ A letter from the employer indicating the reason they are no longer offering group health benefits.

If the applicant's COBRA/Cal-COBRA ended and was not exhausted, we will need:

☐ A letter from the prior employer indicating the reason why COBRA/Cal-COBRA could not be exhausted.

Payment must be provided within 30 days of Anthem approving your application for coverage. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

Overview of coverage — your HIPAA plan choices

... and your share of costs (after deductible, if any)

	HIPAA PPO Share 5000		HIPAA PPO Share 7500	
Your Plan Features	**Network**	**Non-Network**	**Network**	**Non-Network**
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Out-of-Pocket Maximum (In addition to deductible)	$2,500 per member		$0 per member	
Calendar Year Deductible	$5,000 per member		$7,500 per member	
How family deductibles and family out-of-pocket maximums work	Each family member has an individual out-of-pocket maximum. Once 2 members each reach their individual out-of-pocket maximum, the maximum is met for the entire family. Each family member has an individual deductible. Once 2 members each reach their individual deductible, the deductible is met for the entire family.			
Doctor's Office Visits	$40 copay (deductible waived)	50% coinsurance (deductible waived)	$40 copay (deductible waived)	50% coinsurance (deductible waived)
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	30% coinsurance	50% coinsurance	0% coinsurance	0% coinsurance
Inpatient Services (overnight hospital/facility stays)	30% coinsurance	All charges except $650/day	0% coinsurance	All charges except $650/day
Outpatient Services (without overnight hospital/facility stays)	30% coinsurance	All charges except $380/day	0% coinsurance	All charges except $380/day
Emergency Room Services (in a medical emergency)	30% coinsurance plus $100 Emergency Room copay (copay waived if admitted)	30% coinsurance plus $100 Emergency Room copay (copay waived if admitted)	0% coinsurance plus $100 Emergency Room copay (copay waived if admitted)	0% coinsurance plus $100 Emergency Room copay (copay waived if admitted)
Maternity	Maternity services are covered as other services outlined above in this benefit guide.			
Preventive Care	Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, mammograms and more.	50% coinsurance (deductible waived)	Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, mammograms and more.	50% coinsurance (deductible waived)
Prescription Drugs (Anthem Blue Cross Formulary) Amounts shown for each 30-day retail or in-network mail order supply	Generic (Tier 1): $15 copay Brand-name (Tier 2): $35 copay after $750 annual brand name deductible (2 member maximum)	50% of drug limited-fee schedule and all excess charges plus the copay/ coinsurance as stated for in-network benefits; subject to the annual $750 brand name prescription drug deductible	Generic (Tier 1): $15 copay or 40%, whichever is greater Brand name (Tier 2): $15 copay or 40%, whichever is greater after $750 annual brand name deductible (2 member maximum)	50% of drug limited-fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual $750 brand name prescription drug deductible

A more detailed listing of coverage can be found in the Evidence of Coverage/Certificate booklet. For a copy, call Anthem Blue Cross at 800-333-0912.
Notes for HIPAA PPO Share 5000 and PPO Share 7500 plans:
— Discounted rates apply for network covered services.
— For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
— Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.
— Coinsurance is designated by the plan you choose.
This overview provides a brief summary of benefits and services. A more detailed listing of coverage can be found in the Evidence of Coverage/Certificate booklet. For a copy, contact your agent or call Anthem Blue Cross at 800-333-0912.

Your Plan Features	HIPAA ClearProtection Plus 1000		HIPAA ClearProtection Plus 5000	
	Network	**Non-Network**	**Network**	**Non-Network**
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Out-of-Pocket Maximum (Includes both Inpatient/ Surgical and Outpatient/ Professional deductibles or a combination of both)	$4,500 per individual, $9,000 per family		$8,500 per individual, $17,000 per family	
Calendar Year Deductible Inpatient/Surgical and Emergency Room Services	$1,000 per individual, $2,000 per family		$5,000 per individual, $10,000 per family	
Calendar Year Deductible Outpatient/Professional and Diagnostic Services	$4,500 per individual, $9,000 per family		$8,500 per individual, $17,000 per family	
How family deductibles and family out-of-pocket maximums work	Once one family member reaches their deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.			
Doctor's Office Visits	*Network*: First 2 office visits per member: $40 copay, deductible waived. Additional office visits: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible *Non-network*: 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	*Network*: Inpatient: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible *Non-network*: Inpatient: 50% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Inpatient Services (overnight hospital/facility stays)	*Network*: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible *Non-network*: All charges except $650 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible			
Outpatient Services (without overnight hospital/ facility stays)	*Network*: Surgery: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible *Network Other Services:* 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible *Non-network Surgery:* All charges except $380 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible *Non-network Other Services:* 100% coinsurance; then 50% after satisfying Outpatient/Professional and Diagnostic Services deductible			
Emergency Room Services (in a medical emergency)	*Network and non-network*: 40% coinsurance plus $100 Emergency Room copay (copay waived if admitted overnight) after satisfying Inpatient/Surgical and Emergency Room Services deductible			
Maternity	Maternity services are covered as other services outlined above in the covered services section of this benefit guide.			
Preventive Care	Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, mammograms and more. *Network*: 0% coinsurance, not subject to either deductible *Non-network*: 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Prescription Drugs	*Network*: Generic (Tier 1): $15 copay $7,500 annual Prescription Drug deductible per member applies before the following: Formulary brand name (Tier 2): $40 copay Non-Formulary brand name (Tier 3): $60 copay Specialty: 25% coinsurance up to a $2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay) for network only and in addition to $7,500 annual deductible. *Non-network*: Not covered			

Network and non-network deductible are combined and accumulate toward each other. Network and non-network out-of-pocket maximums are also combined and accumulate toward each other.

NOTES: Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.

What the medical plans do not cover

Every health plan has exclusions and limitations that describe what the plans do not cover. General exclusions and limitations are listed below for the health plans described in this brochure. Please take a few moments to review these listings. We want you to understand what your coverage does not include before you enroll. These listings are an overview only. Plan-specific Evidence of Coverage and Disclosure Form/Certificate booklets contain a comprehensive list of each plan's exclusions and limitations. For a sample copy of an Evidence of Coverage and Disclosure Form/Certificate booklet, ask your agent or contact us at 800-333-0912.

Exclusions and limitations

- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state, federal or foreign government, unless you have to pay for them
- Services or supplies not specifically listed as covered under the plan agreement
- Services received before your effective date
- Services received after coverage ends
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered)
- Any amounts in excess of the maximum amounts listed in the Evidence of Coverage and Disclosure Form/Certificate
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction, except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Hearing aids
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Mental and nervous disorders and substance abuse, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Outdoor treatment programs
- Telephone, facsimile machine and electronic consultations
- Educational services, except as specifically provided or arranged by Anthem Blue Cross
- Nutritional counseling
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/Certificate
- Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting

Medical rating area definitions — for HIPAA PPO Share 5000, HIPAA PPO Share 7500, Clear Protection Plus 1000, Clear Protection Plus 5000

Rates for the Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company HIPAA plans are based upon the county in which you reside, your family status and age. For Subscriber & Spouse and Family, rates are based on the age of the younger spouse. To determine your rate, find your county in the Rating Areas chart below and the rate for your area and category on the rate tables. Rates are recalculated at each billing period based on age and the residence address.

Rating areas

Area 1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba
Area 2	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus
Area 3	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara
Area 4	Orange, Santa Barbara, Ventura
Area 5	Los Angeles
Area 6	Riverside, San Bernardino, San Diego

Monthly rates

HIPAA PPO Share 5000 and HIPAA PPO Share 7500

Effective June 1, 2013

		Pricing Area					
	Age Range	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	$396	$358	$367	$341	$355	$338
	15-29	$515	$447	$455	$429	$447	$423
	30-34	$683	$566	$572	$546	$569	$534
	35-39	$767	$625	$629	$605	$631	$589
	40-44	$778	$660	$670	$637	$661	$623
	45-49	$774	$684	$699	$655	$682	$648
	50-54	$964	$825	$839	$794	$826	$780
	55-59	$1,144	$965	$977	$931	$969	$912
	60-64	$1,144	$965	$977	$931	$969	$912
	65-69	$1,768	$1,641	$1,688	$1,584	$1,651	$1,588
	70-74	$1,865	$1,731	$1,780	$1,670	$1,740	$1,673
	75+	$1,976	$1,835	$1,886	$1,769	$1,843	$1,772
Subscriber & Spouse	<15	$715	$677	$702	$640	$667	$642
	15-29	$1,063	$932	$950	$893	$931	$883
	30-34	$1,247	$1,079	$1,100	$1,035	$1,079	$1,021
	35-39	$1,362	$1,184	$1,205	$1,136	$1,183	$1,121
	40-44	$1,327	$1,215	$1,252	$1,158	$1,204	$1,153
	45-49	$1,525	$1,340	$1,369	$1,285	$1,338	$1,270
	50-54	$1,897	$1,638	$1,669	$1,576	$1,640	$1,551
	55-59	$2,251	$1,890	$1,913	$1,827	$1,900	$1,786
	60-64	$2,251	$1,890	$1,913	$1,827	$1,900	$1,786
	65-69	$3,295	$2,991	$3,069	$2,902	$3,023	$2,894
	70-74	$3,474	$3,154	$3,234	$3,060	$3,187	$3,052
	75+	$3,678	$3,338	$3,420	$3,247	$3,383	$3,240
Subscriber & Child	<15	$715	$677	$702	$640	$667	$642
	15-29	$1,063	$932	$950	$893	$931	$883
	30-34	$1,247	$1,079	$1,100	$1,035	$1,079	$1,021
	35-39	$1,362	$1,184	$1,205	$1,136	$1,183	$1,121
	40-44	$1,327	$1,215	$1,252	$1,158	$1,204	$1,153
	45-49	$1,525	$1,340	$1,369	$1,285	$1,338	$1,270
	50-54	$1,897	$1,638	$1,669	$1,576	$1,640	$1,551
	55-59	$2,251	$1,890	$1,913	$1,827	$1,900	$1,786
	60-64	$2,251	$1,890	$1,913	$1,827	$1,900	$1,786
	65-69	$3,295	$2,991	$3,069	$2,902	$3,023	$2,894
	70-74	$3,474	$3,154	$3,234	$3,060	$3,187	$3,052
	75+	$3,678	$3,338	$3,420	$3,247	$3,383	$3,240
Family	<15	$1,163	$1,135	$1,183	$1,068	$1,114	$1,080
	15-29	$1,748	$1,530	$1,560	$1,534	$1,599	$1,524
	30-34	$2,088	$1,838	$1,874	$1,760	$1,835	$1,743
	35-39	$2,049	$1,820	$1,860	$1,742	$1,809	$1,722
	40-44	$2,002	$1,806	$1,853	$1,727	$1,799	$1,717
	45-49	$2,168	$1,890	$1,927	$1,817	$1,890	$1,792
	50-54	$2,477	$2,130	$2,167	$2,051	$2,133	$2,016
	55-59	$2,751	$2,269	$2,289	$2,198	$2,285	$2,140
	60-64	$2,751	$2,269	$2,289	$2,198	$2,285	$2,140
	65-69	$4,065	$3,777	$3,886	$3,599	$3,750	$3,601
	70-74	$4,287	$3,987	$4,100	$3,795	$3,954	$3,798
	75+	$4,539	$4,221	$4,337	$4,028	$4,197	$4,032
Subscriber & Children	<15	$1,163	$1,135	$1,183	$1,068	$1,114	$1,080
	15-29	$1,748	$1,530	$1,560	$1,534	$1,599	$1,524
	30-34	$2,088	$1,838	$1,874	$1,760	$1,835	$1,743
	35-39	$2,049	$1,820	$1,860	$1,742	$1,809	$1,722
	40-44	$2,002	$1,806	$1,853	$1,727	$1,799	$1,717
	45-49	$2,168	$1,890	$1,927	$1,817	$1,890	$1,792
	50-54	$2,477	$2,130	$2,167	$2,051	$2,133	$2,016
	55-59	$2,751	$2,269	$2,289	$2,198	$2,285	$2,140
	60-64	$2,751	$2,269	$2,289	$2,198	$2,285	$2,140
	65-69	$4,065	$3,777	$3,886	$3,599	$3,750	$3,601
	70-74	$4,287	$3,987	$4,100	$3,795	$3,954	$3,798
	75+	$4,539	$4,221	$3,337	$4,028	$4,197	$4,032

The HIPAA PPO Share 5000 and HIPAA PPO Share 7500 plans are offered by Anthem Blue Cross Life and Health Insurance Company.

Notes:
For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
For more information, call your agent or Anthem Blue Cross at 800-333-0912.

Monthly rates

ClearProtection Plus 1000 and ClearProtection Plus 5000

Effective June 1, 2013

		Pricing Area					
	Age Range	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	$395	$358	$367	$341	$354	$338
	15-29	$513	$446	$454	$428	$447	$422
	30-34	$680	$564	$571	$545	$569	$532
	35-39	$764	$623	$628	$604	$630	$587
	40-44	$775	$658	$669	$637	$660	$622
	45-49	$772	$638	$669	$656	$682	$647
	50-54	$961	$823	$838	$795	$826	$779
	55-59	$1,140	$962	$975	$932	$968	$910
	60-64	$1,140	$962	$975	$932	$968	$910
	65-69	$1,766	$1,640	$1,687	$1,585	$1,651	$1,587
	70-74	$1,862	$1,730	$1,778	$1,670	$1,740	$1,672
	75+	$1,973	$1,834	$1,884	$1,769	$1,843	$1,772
Subscriber & Spouse	<15	$715	$677	$701	$640	$667	$642
	15-29	$1,061	$930	$948	$892	$931	$881
	30-34	$1,243	$1,077	$1,098	$1,033	$1,078	$1,019
	35-39	$1,358	$1,181	$1,203	$1,135	$1,183	$1,118
	40-44	$1,325	$1,214	$1,251	$1,159	$1,204	$1,152
	45-49	$1,521	$1,338	$1,367	$1,286	$1,337	$1,268
	50-54	$1,892	$1,634	$1,667	$1,576	$1,639	$1,548
	55-59	$2,243	$1,885	$1,909	$1,827	$1,898	$1,782
	60-64	$2,243	$1,885	$1,909	$1,827	$1,898	$1,782
	65-69	$3,290	$2,987	$3,067	$2,902	$3,022	$2,892
	70-74	$3,468	$3,151	$3,232	$3,060	$3,186	$3,049
	75+	$3,672	$3,334	$3,417	$3,248	$3,382	$3,237
Subscriber & Child	<15	$715	$677	$701	$640	$667	$642
	15-29	$1,061	$930	$948	$892	$931	$881
	30-34	$1,243	$1,077	$1,098	$1,033	$1,078	$1,019
	35-39	$1,358	$1,181	$1,203	$1,135	$1,183	$1,118
	40-44	$1,325	$1,214	$1,251	$1,159	$1,204	$1,152
	45-49	$1,521	$1,338	$1,367	$1,286	$1,337	$1,268
	50-54	$1,892	$1,634	$1,667	$1,576	$1,639	$1,548
	55-59	$2,243	$1,885	$1,909	$1,827	$1,898	$1,782
	60-64	$2,243	$1,885	$1,909	$1,827	$1,898	$1,782
	65-69	$3,290	$2,987	$3,067	$2,902	$3,022	$2,892
	70-74	$3,468	$3,151	$3,232	$3,060	$3,186	$3,049
	75+	$3,672	$3,334	$3,417	$3,248	$3,382	$3,237
Family	<15	$1,163	$1,135	$1,182	$1,068	$1,114	$1,080
	15-29	$1,744	$1,527	$1,558	$1,533	$1,598	$1,523
	30-34	$2,083	$1,834	$1,872	$1,759	$1,834	$1,739
	35-39	$2,045	$1,816	$1,858	$1,742	$1,809	$1,720
	40-44	$1,999	$1,804	$1,852	$1,728	$1,798	$1,715
	45-49	$2,162	$1,886	$1,924	$1,817	$1,890	$1,789
	50-54	$2,470	$2,125	$2,164	$2,051	$2,132	$2,013
	55-59	$2,741	$2,261	$2,285	$2,199	$2,284	$2,135
	60-64	$2,741	$2,261	$2,285	$2,199	$2,284	$2,135
	65-69	$4,060	$3,774	$3,884	$3,599	$3,749	$3,599
	70-74	$4,282	$3,985	$4,098	$3,795	$3,953	$3,796
	75+	$4,534	$4,218	$4,334	$4,028	$4,196	$4,030
Subscriber & Children	<15	$1,163	$1,135	$1,182	$1,068	$1,114	$1,080
	15-29	$1,744	$1,527	$1,558	$1,533	$1,598	$1,523
	30-34	$2,083	$1,834	$1,872	$1,759	$1,834	$1,739
	35-39	$2,045	$1,816	$1,858	$1,742	$1,809	$1,720
	40-44	$1,999	$1,804	$1,852	$1,728	$1,798	$1,715
	45-49	$2,162	$1,886	$1,924	$1,817	$1,890	$1,789
	50-54	$2,470	$2,125	$2,164	$2,051	$2,132	$2,013
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	70-74	$4,282	$3,985	$4,098	$3,795	$3,953	$3,796
	75+	$4,534	$4,218	$4,334	$4,028	$4,196	$4,030

Notes:
For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
For more information, call your agent or Anthem Blue Cross at 800-333-0912.

No-obligation review period

After you enroll in an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company health plan, you will receive an Evidence of Coverage/Certificate booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have 30 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Evidence of Coverage/Certificate booklet along with a letter notifying us that you wish to discontinue coverage. Evidence of Coverage/Certificate booklets are available for you to examine prior to enrolling by contacting your agent or calling Anthem Blue Cross at 800-333-0912. Once you enroll in an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company HIPAA plan, you will have 30 days from the date of enrollment to change to a different HIPAA plan. Your effective date will be the same as the date of your original enrollment. No further changes will be allowed after you have been enrolled for 30 days.

Incurred medical care ratio

Law requires us to tell you that Anthem Blue Cross' medical loss ratio for 2011 was 80.9%. The 2011 medical loss ratio for Anthem Blue Cross Life and Health Insurance Company was 79.9%. These ratios were calculated after provider discounts were applied, and are based on state and federal regulatory rules and regulations, including the federal MLR regulations.

Utilization management and case management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective review/Pre-admission review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary, and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

This brochure provides a brief summary of benefits and services. If there is any difference between this brochure and the Evidence of Coverage/Certificate, the Evidence of Coverage/Certificate will prevail.
The plan benefits in this brochure comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to the Evidence of Coverage/Certificate.

To view a Summary of Benefits and Coverage please visit www.healthcare.gov.

Application for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)

Anthem BlueCross

1. Applicant Information

Please print in blue or black ink

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)*		
City	State	ZIP

*All information will be mailed to your Home Address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Mailing Address" field below. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").

2. Choice of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Individual Coverage

Choose one plan per application

- ☐ HIPAA ClearProtection Plus 1000 (0JT9)
- ☐ HIPAA ClearProtection Plus 5000 (0JTA)
- ☐ HIPAA PPO Share 5000 (0JT7)**
- ☐ HIPAA PPO Share 7500 (0JT8)**

Mailing Address (if different than above) or P.O. Box, Private Mail Box (PMB) No.		Daytime Phone No. ( )	Fax Phone No. ( )
City / State / ZIP	County (Required)	Marital Status ☐Single ☐Domestic Partnership ☐Married	Applicant/Spouse Maiden Name
Email	If possible, do you want email notification? ☐ Yes ☐ No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No	

Language Choice *(Optional)* ☐ English (ENG) ☐ Vietnamese (VIE) ☐ Korean (KOR) ☐ Tagalog (TGL) ☐ Spanish (SPA) ☐ Other (W09)_____ ☐ Chinese (ZHO) (C/M)

☐ Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (see Section 7).

**These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.

3. Family Members and Dependents Applying

Please list ALL eligible family members and dependents applying.
If a listed family member or dependent's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name First Name M	Social Security or ID No.	Date of Birth	Age
10 ☐ Male 20 ☐ Female	Yourself			
30 ☐ Male 40 ☐ Female	Spouse***			
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				

***Spouse includes domestic partner (when applicable). Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn 26). (List all dependents beginning with the eldest.)

4. Eligibility

1. Have all applicants had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No

   If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.

   Name of insurance carrier: _____ Phone No. (____) _____

   If no for any applicant, then he or she is **not eligible** for this guarantee issue plan.

2. Did all applicants elect and exhaust any continuation coverage available under COBRA or Cal-COBRA? ☐ Yes ☐ No

   If yes, date coverage started (Mo/Day/Yr) _____ Date coverage ended (Mo/Day/Yr) _____

   If no, please explain: _____

   If all available COBRA or Cal-COBRA is not exhausted for any applicant, then he or she is **not eligible** for this coverage.

3. Is any applicant currently covered by or eligible for Medicaid, Medicare or any health coverage? ☐ Yes ☐ No

   If yes for any applicant, then he or she is **not eligible** for this coverage.

4. Has any applicant lost coverage for fraud or failure to pay premiums? ☐ Yes ☐ No

   If yes, then he or she is **not eligible** for this coverage.

5. Prior Insurance History

For any period of creditable coverage for which you are unable to provide a certificate of creditable coverage, please complete the following section for the last two years, beginning with the most recent coverage. Please include any COBRA and Cal-COBRA continuation coverage. Attach additional sheet if necessary.

Applicant name(s) OR ☐ All applicants	Insurer Name (and Phone Number)	Policyholder ID Number	
Plan/Policy Name	State	Effective Date of Coverage	Coverage End Date

Type of Coverage: ☐ Group ☐ Individual ☐ Other

6. Application Understandings, Conditions and Agreement

IMPORTANT: To the best of my information and belief, I, the applicant am solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy for which I am applying, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-800-333-0912 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company based on when payment is received. Anthem will send you billing information within 30 days of approving your application. Payment must be provided within 30 days. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
3. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
4. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
5. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company my premium payment that is directly funded by the regular wages paid to me by my employer.
6. ☐ By checking this box, I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.
7. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
8. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.

6. Application Understandings, Conditions and Agreement - continued

To the best of my information and belief, I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me.

I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 7) all persons applying for coverage agree that they have personally answered all questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 7)

REQUIREMENTS FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ***It is understood that any disputes including disputes relating to the delivery of services under the plan/policy and/or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU, ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.**

Signatures (Required) **– IMPORTANT: All applicants age 18 and over must personally read, agree to, sign and date this application.**

Applicant/Parent or Legal Guardian **X**	Today's Date	Applicant's Spouse/Domestic Partner **X**	Today's Date
Applicant's Dependent age 18 or over **X**	Today's Date	Applicant's Dependent age 18 or over **X**	Today's Date

■ **IMPORTANT: All signatures MUST include today's date** ■

7. Statement of Accountability – Complete when the applicant cannot fill out the application for coverage under HIPAA.

I, _____ , personally read and completed this application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English
☐ Applicant does not write English ☐ Applicant is Limited English Proficient ☐ Other (explain):_____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by the: ☐ Applicant or by: _____

I also interpreted and fully explained the "Application Understandings and the Conditions and Agreement."

Signature of Interpreter *(Required)* **X**	Today's Date *(Required)*
I confirm that the application was interpreted on my behalf. Signature of Applicant *(Required)* **X**	Today's Date *(Required)*

Language interpreted (e.g. Spanish): _____

8. To be completed by the Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Appointed Agent

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting?..... ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ..... ☐ Yes ☐ No
   If no, please explain: _____
   _____
3. I certify that, to the best of my knowledge and belief, the responses herein are accurate.
4. Please check one of the following and complete the information below:
   - ☐ I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.
   - ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Signature of Agent (Required)		Date (Required)
Name of Agent (Print name)		Agent's Street Address Suite No.
Agent ID No.		City / State / ZIP
Phone No. ( )	Fax No. ( )	Email

Please mail to:

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9041
Oxnard, CA 93031-9041

OR

Fax to: 1-800-327-9255

Payment Methods for Individual Applications – California

Applicant / Member Name:	Primary Applicant's SSN:

(Premium Payment is required. Please choose from Option 1 or 2.)

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Checking Account Automatic Premium Payment (complete Section A)

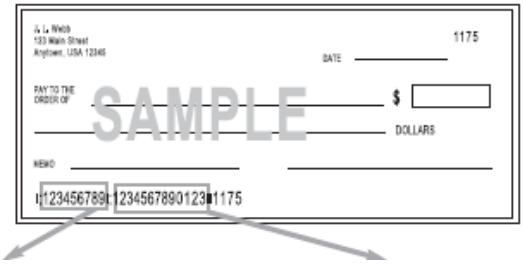
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. If you choose one of these options, you will receive a bill every month thereafter.

☐ Paper Check* ☐ Electronic Check (complete Section B) ☐ Credit / Debit Card (complete Section C)

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED, YOU WILL BE BILLED.

A. Monthly Checking Account Automatic Premium Payment – By providing your check information, you authorize us to electronically debit your bank account. If you have selected this option, your bank account will be debited one month's premium as soon as the day of approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below:

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.



Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Check Number	Amount
				$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross to charge my card for a one time initial debit upon approval. I understand that if this option is selected, my account will be debited one month of premium as soon as the day of approval. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number:	Expiration Date:	Cardholder Zip Code:
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|	|__|__| / |__|__|	|__|__|__|__|__| – |__|__|__|__|

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.