BLUE CHOICE©
PPO

CERTIFICATE OF COVERAGE

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your id card or in your Certificate of Coverage.

030171 R 1/2019 RX: 4-Tier (No HDC)

Notices Required by State Law

Paying Subscription Charges and Renewal

Coverage is provided as stated in the Group Agreement. The coverage will renew automatically from year to year on the Anniversary/Renewal Date for additional one-year terms unless the Group or Anthem Blue Cross and Blue Shield gives written notice of termination, subject to the provisions in the Group Agreement. Any modifications that we make to this Plan will be communicated to you 60-days prior to the date of the plan change.

Payment for subscription charges is due the first day of each month. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Network Disclosure Notice

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS: There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as co-insurance, co-payments, and out of pocket maximums may be higher if you use a non-network provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact Member Services for assistance.

Federal Patient Protection and Affordable Care Act Notice

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Notice Regarding Breast Cancer Patient Protection Act

Under this plan, as required by the Maine Breast Cancer Patient Protection Act of 1997, coverage will be provided for inpatient care subsequent to the mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer for a period of time determined to be medically appropriate by the attending physician in conjunction with the patient.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits Medical Necessity criteria available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

As required by Maine law, this Booklet is being provided to you as an enrollee of the group health plan sponsored by the employer group listed on the Schedule of Benefits. The Booklet explains the essential features of your insurance coverage and the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

Your Group has agreed to be subject to the terms and conditions of Anthem BCBS's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

No agent has authority to change the policy or to waive any of its provisions. No change in the policy shall be valid unless approved by an officer of the insurer and evidenced by indorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

Kathleen S. Kiefer
Corporate Secretary
Anthem Blue Cross and Blue Shield

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Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That also means giving you access to our network of health care providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your health care providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your plan.
- Work with your doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - our company and services.
    - our network of health care providers.
    - your rights and responsibilities.
    - the rules of your health plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health plan and any care you receive.
    - any Covered Service or benefit decision that your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care you may get in the future. This includes asking your doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by calling the Customer services number on your ID card or by visiting www.anthem.com.
- Or contact your local insurance department.
  Phone: (800) 300-5000
  Write: Bureau of Insurance Department of Professional and Financial Regulation
  #34 State House Station
  Augusta, ME 04333-0034

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose a network primary care physician, also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.

- Give us, your doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform Customer services if you have any changes to your name, address or family members covered under your plan.

If you would like more information, have comments, or would like to contact us, please go to anthem.com and select Customer Support>Contact Us. Or call the Customer Services number on your ID card.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

We are committed to communicating with our members about their health plan, regardless of their language. We employ a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Section One
Eligibility, Termination, and Continuation of Coverage

Eligibility

Beginning Coverage
Before your coverage begins we must accept the Group's application, your application, and payment for your coverage. The Contract Holder acts as your remitting agent and is responsible for sending us all applications and payments for coverage, as well as notifying the Subscriber of any changes in payroll deductions for coverage, rate changes, changes in this Contract or in any documents that comprise the Contract, or termination of the Contract or your coverage under the Group Contract.

Paying Subscription Charges
Payment for Subscription Charges is due the first day of each month of coverage. To keep this coverage in effect, your Contract Holder must pay the Subscription Charges when due. If payment is received within 31 days of the due date - - the Grace Period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the Grace Period. We reserve the right to take necessary action to collect premiums for the Grace Period.

Who is an Eligible Group Member?
1. The Subscriber;
2. The Subscriber's legal spouse, unless spouses are not eligible under the Group's Plan. If spouses are not eligible under this Plan, any references to 'spouse' in this booklet will not apply. (For information on spousal eligibility please contact the Group);
3. The Subscriber's/spouse's children under age 26:
   a. Newborn children
   b. Biological Children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the Subscriber or children for which the Subscriber is a legal guardian;
4. The Subscriber's/spouse's unmarried children aged 26 and older if they are mentally or physically disabled. The disability must have begun before the child's 26th birthday, and the child must have been covered by us on and continuously since his or her 26th birthday.
5. The Subscriber's grandchild under age 26, living with the Subscriber in a parent-child relationship and primarily supported by the Subscriber. The Subscriber may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, and meet all Dependent eligibility criteria established by the Group.

Nondiscrimination No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Please note: Spouses of married dependent children are not eligible for coverage.

We will determine the effective date of coverage for the Subscriber and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call us.

We reserve the right to verify continued eligibility for all Members.

Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for medical coverage as stated in the order. A Qualified Medical Child Support Order is a judgment, decree, or order issued by a court of law which:

- Specifies your name and last known address;
- Specifies the child's name and last known address;
- Provides a description of the coverage to be provided or the manner in which the type of coverage is to be determined;
- States the period of time to which it applies; and
- Specifies each plan to which it applies.

A Qualified Medical Child Support Order may not require health care coverage that is not already included under the Plan.

Membership Additions

If you wish to add eligible family members after we have accepted your application, you must:

- Notify the Contract Holder;
- File an application; and
- Pay the applicable Subscription Charge.

In most cases, the effective date of coverage for added family members will not be the same as your effective date of coverage. The Contract Holder can tell you when enrollment for added family members is allowed under this Group Contract.

Family members who are eligible because of birth, adoption, marriage, court order, or dependent losing eligibility under other coverage after the Subscriber's effective date of coverage may be added as follows:

Birth A newborn is automatically covered for 31 days from the moment of its birth unless the Subscriber notifies us that the child will not be covered under the Contract. For coverage beyond 31 days, if we receive a completed application for change:

- **Within 31 days from the date of birth**, coverage is continuous from the moment of birth. We will collect applicable charges.
- **After 31 days from the date of birth**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Adoption If we receive an adopted child's application for change:

- **Within 31 days from the date the child is adopted or placed for adoption with the Subscriber and/or spouse**, coverage will begin on the date of placement. We will collect applicable charges. If a child placed for adoption is not adopted, all health care coverage will cease when placement ends. No continuation provisions will apply.
- **After 31 days from the date the child is adopted or placed for adoption with the Subscriber and/or spouse**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Marriage When the Subscriber marries, if we receive the spouse's (and children's, if applicable) completed application for change:

- **Within 31 days from the date of marriage**, coverage begins the first of the month that occurs immediately on or after the date we receive the application.
- **After 31 days from the date of marriage**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Court Order Changing Custody When a court order is issued changing custody of a Dependent child, if we receive the application for change:

- **Within 31 days of the date of the court order**, coverage will begin on the date of the court order.
- **After 31 days from the date of the court order**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

Dependent Losing Eligibility Under Other Coverage When a dependent with other coverage loses that coverage, if we receive the application for change:

- **Within 31 days of the date the dependent loses coverage**, coverage will begin on the date of application for enrollment.
- **After 31 days from the date of the court order**, coverage will begin on the Group's next annual Late Enrollee Enrollment Period.

If the eligible individual is not already enrolled or is enrolled in a different benefit package, the individual may enroll during this period.

Annual Late Enrollee Enrollment Period After the initial eligibility date, applications may be submitted during the annual Late Enrollee Enrollment Period agreed to by us and your employer.

Late Enrollee A Late Enrollee is a Subscriber or a Dependent family member who requests enrollment under the Contract Holder's Group health plan following the initial Enrollment Period provided under the terms of the plan; or a Subscriber or Dependent family member who enrolls after 31 days following any of the life events described below. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment.

Exception for Late Enrollees A person is not considered a Late Enrollee if he/she incurs a claim under a prior contract or policy that would meet or exceed that contract or policies lifetime limit on all benefits, and a request for enrollment is made not later than 31 days after a claim is denied in whole or in part due to the operation of a lifetime limit on all benefits.

Qualifying Life Events After initial eligibility, applications may also be submitted within 31 days of certain qualifying life events. Ineligibility caused by fraud or misrepresentation does not qualify. Qualifying life events include:

- Marriage;
- Divorce or legal separation;
- Death of a spouse, or Dependent child;
- Birth, adoption, or placement for adoption;
- Termination or commencement of spouse's employment;
- Change in employment of the employee or spouse, from full-time to part-time status or part-time to full-time status;
- The taking of an unpaid leave of absence by the Subscriber or his/her spouse;
- Termination of the Group Contract;
- A court order requires that coverage be provided for the Subscriber's spouse or the minor child of the Subscriber or the Subscriber's spouse;
- A court order is issued changing custody of a child. The effective date of coverage is the date of the court order;
- You have exhausted your Consolidated Omnibus Budget Reconciliation Act (COBRA) Benefits;
- A Dependent satisfying or ceasing to satisfy the requirements for unmarried Dependents;
- Loss of Medicaid.

The Contract Holder can tell you when enrollment for added family members is allowed under this Group Contract.

Special Enrollment If you decline coverage for yourself or your Dependents (including your spouse) because you and your Dependents are covered under other health insurance coverage, you may in the future be able to enroll yourself or your Dependents, provided you meet each of the applicable conditions outlined below, and you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.

Conditions required for enrollment:

1. The employee has declined enrollment in writing stating that coverage under other health insurance coverage was the reason for declining coverage;
2. When the employee declined enrollment in employee and/or Dependent coverage, the employee and/or Dependent had COBRA continuation coverage under other health insurance and COBRA continuation coverage under that other insurer has since been exhausted; or
3. If the other coverage that applied to the employee and/or Dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
   a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing;
   b. employer contributions towards the other coverage have been terminated; or
   c. loss of coverage under the Cub Care program.
   d. the member no longer resides in such coverage's permitted service area provided that no other coverage under the plan is available to the Member;
   e. benefits are no longer offered to a class of similarly situated individuals. For example, if a Plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the Plan continues to provide coverage to other employees;
   f. the application of the lifetime maximum benefit through another carrier's coverage;
   g. a dependent loses eligible dependent status. An employee who is already enrolled in a benefit option may enroll in another option under the Plan due to a dependent losing eligible dependent status; or
   h. a dependent who has other coverage loses eligibility under that coverage.

You are not required to elect and exhaust COBRA coverage under another plan to enroll in this Plan during a special enrollment period. If you do elect COBRA coverage under another plan, however, you must exhaust your COBRA coverage under that plan before you can elect to participate in this Plan. Special enrollment rights do not apply if you lose other coverage because you failed to pay your COBRA premiums.

Under the Children's Health Insurance Program Reauthorization Act of 2009, effective April 1, 2009, two new special enrollment opportunities to elect coverage have been created under your group health plan. These are in addition to the special enrollment opportunities already described in your benefit plan documents:

A special enrollment period of 60 days will be allowed under two additional circumstances:

- If your or your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility; or
- If you or your eligible dependent become eligible for premium assistance under a state Medicaid or SCHIP plan.

Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/SCHIP coverage or of the determination of eligibility for premium assistance under Medicaid/SCHIP.

Return From Military Service

If you return from full-time active service following a call to active military duty, no waiting period applies. You and eligible family Members can reenroll in the Plan, provided you apply for reemployment within the timeframe permitted under the Uniformed Services Employment and Reemployment Rights Act. The time period allowed for reemployment depends on the length of your active military duty. To reenroll in the Plan, your application must be received within 31 days of your reemployment date. Coverage is effective on the effective date of your reemployment.

Termination of Coverage

The Subscriber, the Contract Holder, or we can cause your coverage to end. If your coverage ends for any reason except misrepresentation, fraud or nonpayment, it will end on the first day following the Grace Period (see "Paying Subscription Charges" earlier in this section for additional information). If termination of coverage is requested before the completion of the period for which we have accepted payment, payment may not be refunded, and coverage may continue until the end of that period. We reserve the right to take necessary action to collect premiums for the Grace Period.

Cancellation of the Group Contract

Notice of Cancellation If Group coverage is canceled as a result of the responsible individual's cognitive impairment or functional incapacity, the Group or subgroup may be eligible for reinstatement. The responsible individual is the person who is responsible for making premium payments on behalf of a Group or subgroup.

The right to reinstate Group coverage has the same limitations and requirements as listed in the "Notice of Cancellation" and "Right to Reinstatement" provisions as described in the "Cancellation of the Member's Contract" subsection.

This does not limit our right to cancel Group or subgroup coverage on the grounds that the employer is no longer in business, even if the end of the business results from the employer's cognitive impairment or functional incapacity.

By Notice Your Group may cancel this Contract by giving us prior written notice. It is the responsibility of your Group to notify the Subscriber of change in insurance carriers. All rights to Benefits under this Contract end on the date of cancellation.

For Non-Payment If the Group fails to pay the Subscription Charge, we may cancel the Contract. If the Group Contract is canceled for non-payment, we will notify the Subscriber of the cancellation prior to the termination date of the Contract. We will not notify the Subscriber of cancellation if the Group provides notice to us that coverage has been replaced. Your coverage will continue in force for a Grace Period of 31 days from the date Group payment is due for the Subscription Charge.

Non-Renewal Your Group may cancel the Contract by not renewing the Group Contract with us. We may cancel the Contract by not renewing the Group Contract if membership in your Group falls below the minimum number of Subscribers we require.

Other Cancellation Events We may cancel the Group's Contract if the Group gives us fraudulent information, if the Group does not meet our participation or contribution requirements, or if the Group moves outside of the geographic area we serve.

Cancellation of the Member's Contract

Ending Employment or Eligibility If the Subscriber ends employment or membership, or if you cease to meet the definition of eligible, as described in this section, your coverage will be canceled. We reserve the right to verify your initial and continued eligibility.

Deletion from Membership If you have been deleted from membership, your coverage will be canceled. The Subscriber must delete a Member from coverage if the Member is no longer eligible for reasons such as the Subscriber's divorce or legal separation, or a Member's death. The Subscriber must notify us of these events and complete a form to remove a Member. If you do not promptly disenroll your Dependents when they are no longer eligible, you will be fully responsible for all claims they incurred and for which Benefits have been paid after they were no longer eligible.

Covered Children Your coverage will be canceled if you are a covered child and:

- You reach age 26 Coverage will continue until the end of the month in which you reach age 26. Coverage will continue if you are an eligible disabled Dependent, as defined in the subsection "Who is an Eligible Group Member?". We reserve the right to request verification of continued eligibility.
- You cease to meet the definition of an eligible Dependent.

Non-Payment of Charges Your Contract will be canceled for your Group's non-payment of Subscription Charges.

Misrepresentation or Fraud If you make any intentional misrepresentation, intentional omission, or use fraudulent means to obtain or continue coverage, your Contract may be rescinded. A rescission may void coverage retroactively. Any claims incurred after the date of rescission for which we are unable to recover payment from the Provider will be the responsibility of the Subscriber.

Notice of Cancellation If your coverage is canceled for non-payment of Subscription Charges or other lapse or default, we will send you a notice of cancellation. We will offer you the opportunity to reinstate your coverage as set forth below. The charges will be the same amount they would have been if the Contract had remained in force. Please refer to the Group Continuation Coverage section, below, for information regarding cancellation of COBRA coverage.

You have the right to designate another person to receive notice of cancellation of this Contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third Party Notice Request Form. You can obtain this form from your Group or by contacting us.

Right to Reinstatement Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity

If you request reinstatement, we may require a Physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate your Contract, you must pay the amount due from the date of cancellation through the month in which we bill you. The charges will be the same amount they would have been if the Contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

Continuation of Coverage

If your Group health coverage ends, you may be eligible for Group continuation coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA).

Group Continuation Coverage

Federal law requires that some employers sponsoring Group health plans offer employees and their families a temporary extension of health coverage at the rate of your Group Subscription Charge plus an administrative fee, when that coverage would otherwise end because of the occurrence of certain qualifying events. You are responsible for payment of the Subscription Charge at your Group rate plus the administration fee.

Qualifying events include:

- Death of the employee;
- Termination of the employee's employment or reduction in hours of employment (other than for gross misconduct);
- Divorce or legal separation from the employee;
- A Dependent child ceasing to be a Dependent;
- A retiree's coverage ceasing because of the employer's bankruptcy; and
- A covered employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act.

Notification - Under the law the employee or a family member (a qualified beneficiary) has the responsibility to inform the employer within 60 days of a:

- Divorce;
- Legal separation; and/or
- Child losing Dependent status under the Group health plan.

In any event, your continued Group coverage under this Contract (COBRA), will end if any of the following events occur:

- Your employer no longer provides our health insurance to any of its employees;
- We do not receive your Subscription Charge payment. In such case, your COBRA coverage will be retroactively terminated to the first day of the period for which the Subscription Charges have not been timely paid;
- You become a covered employee under any other Group health plan after the date you elect COBRA continuation coverage;
- You remarry and become covered under a Group health plan after the date you elect COBRA continuation coverage;
- You become entitled to benefits under Medicare after the date you elect COBRA continuation coverage; or
- Your COBRA entitlement period ends.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Other Coverage Options Besides COBRA Continuation Coverage
Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Continuation of Coverage Due To Military Service

In the event you are no longer actively at work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Military service means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate and upon payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 18-month period (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) may be reinstated under this Certificate.

Section Two

Utilization Management
Getting Approval for Benefits

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

Reviewing Where Services Are Provided

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

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization management criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the utilization review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

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

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

Types of Reviews

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

- **Precertification –** A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit

coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us with 48 hours of admission, or as soon as possible within a reasonable period of time. For childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

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

  Both pre-service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline ad are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need precertification and will get any precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get precertification when required.
Out of Network / Non-Participating	Member	• Member must get precertification when required (Call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
Blue Card Provider	Member (Except for Inpatient Admissions)	• Member must get precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the

		service and or setting is found to not be Medically Necessary. • Blue Card Providers must obtain precertification for all Inpatient admissions.
Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

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

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

If you are not satisfied with our decision under this section of your benefits, please refer to the "Complaints and Appeals" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	48 hours from the receipt of request
Non-Urgent Pre-service Review	2 business days from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	1 business day from the receipt of the request
Urgent/Concurrent Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	1 business day from the receipt of the request
Non-urgent Concurrent Continued Stay Review for ongoing outpatient treatment	1 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written and/or electronic.

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory or contacting the Member Services number on the back of your ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our Health Plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions, including but not limited to Asthma, Heart Disease, Depression, Diabetes, High Blood Pressure & High Cholesterol, Low Back Pain and Pain. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of

Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered. However, the Certificate of Coverage and the Group Agreement take precedence over medical policy. Medical technology is constantly changing and we reserve the right to review and update medical policy periodically.

Network Provider Unavailable

If you are unable to obtain services from a Network Provider, you or your doctor should call the telephone number on your ID card. Our care managers will work with you or your doctor to locate a Network Provider. If it is determined by the care manager that no Network Provider is available, we will authorize Covered Services from a Non-Network Provider. Benefits will be reimbursed at the higher network level.

How to Access Primary and Specialty Care Services

Your health plan covers certain primary and specialty care services. To access primary care services, simply visit any network physician who is a general or family practitioner, internist or pediatrician. Your health plan covers care provided by any network specialty care provider you choose. Referrals are never needed to visit any network specialty care provider.

To make an appointment call your physician's office:

- Tell them you are an Anthem PPO member.
- Have your Member ID card handy. They may ask you for your group number, member I.D. number, or office visit copay.
- Tell them the reason for your visit.

When you go for your appointment, take your Member ID card.

When you need care after normal office hours

After hours care is provided by your physician who may have a variety of ways of addressing your needs. Call your physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays. This includes information about how to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening, but that requires prompt medical attention. If you have an emergency, call 911 or go to the nearest emergency room.

Section Three
Covered Services

This section, along with the "Exclusions" section, explains health care services for which we will and will not provide Benefits. All Benefits and Covered Services are subject to the Deductibles, Coinsurance, Copayments, maximums, exclusions, limitations, terms, provisions and conditions of this Contract, including any attachments and Amendments or riders. Benefits for Covered Services are based on the maximum allowable amount. To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, use of Network Providers and obtaining any required prior authorization.

Our payment for Covered Services will be limited by any applicable Copayment, Deductible, or annual or lifetime maximum. Please check your Schedule of Benefits for Deductibles, Copayments, Coinsurance, maximums, and limitations that apply. Please see the "Utilization Management" section for conditions that apply to all Inpatient admissions.

Benefits for Covered Services may be payable subject to an approved treatment plan. Only medically necessary care is covered. Although we do not provide Benefits for Covered Services that do not meet our definition of medical necessity, you and your Physician must decide what care is appropriate. The fact that a Physician may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. If you choose to receive care that is not a Covered Service or does not meet our definition of medical necessity, we will not provide Benefits for it. Anthem BCBS bases its decisions about referrals, prior authorization, medical necessity, Experimental services and new technology on medical policy developed by Anthem BCBS. Anthem BCBS may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Unless specifically stated otherwise, all Benefits, limitations and exclusions under this Contract apply separately to each covered family member.

A Member's right to Benefits for Covered Services provided under this Certificate is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem BCBS Medical Policy, Continued Inpatient Stay Review, Pre-admission Review, Post-Admission Review, and Prior Authorization. A description of each of these guidelines explaining its purpose, requirements and effects on Benefits is provided in the "Utilization Management" section. Failure to follow the Utilization Management guidelines for obtaining Covered Services will result in reduction or denial of Benefits.

Allergy Testing and Injections We provide Benefits for allergy testing and injections.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;

  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Non-Network Provider.

Non-emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance, for non-emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases we may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:
1. A Doctor's office or clinic;
2. A morgue or funeral home.

Important Notes on Air Ambulance Benefits
Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or a rehabilitation facility, or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport
If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

We provide Benefits for local transportation by a licensed vehicle that is specially designed and equipped to transport the sick and injured. This service is covered only when used locally to or from a Hospital when other transportation would endanger your health.

If no Hospital in your local area is equipped to provide the care you need, we will provide Benefits for ambulance transportation to the nearest facility outside your area that can provide the necessary care. If you are transported to a Hospital that is not the nearest Hospital that can meet your needs, Benefits will be based on transport to the nearest Hospital that can meet your needs.

Ambulatory Surgery Centers We provide Benefits for certain Covered Services provided by ambulatory surgery centers. Covered services vary according to the scope of an individual facility's licensure.

Anesthesia Services We provide Benefits for anesthesia only if administered while a Covered Service is being provided, except as outlined in the 'Dental Procedures' provision. We do not provide Benefits for local or topical anesthesia unless it is part of a regional nerve block.

Autism Spectrum Disorders We provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Please refer to your Schedule of Benefits for limits that may apply.

Blood Transfusions We provide Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Chemotherapy Services We provide Benefits for antineoplastic drugs and associated antibiotics and their administration when they are administered by parenteral means such as intravenous, intramuscular, or intrathecal means. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law.

Benefits are also available for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

Chiropractic Care We provide Benefits for chiropractic care. See the 'Manipulative Therapy' provision for additional information. Please see your Schedule of Benefits for limits that apply.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

a. The enrollee has a life-threatening illness for which no standard treatment is effective;
b. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness
c. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and
d. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs a, b and c.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

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

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services

i. The Investigational item, device, or service; or

ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Contraceptives We provide Benefits for prescription contraceptives approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an Outpatient basis.

Dental Procedures We will provide Benefits for general anesthesia and associated facility charges for dental procedures rendered in a Hospital when the Member is classified as vulnerable. Examples of vulnerable Members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual, or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, can not be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial, or dental trauma
- Individuals who are extremely uncooperative, fearful, or anxious

Dental Services We provide Benefits only for the following:

- Setting a jaw fracture
- Removing a tumor (but not a root cyst)
- Removing impacted or unerupted teeth in a non-Hospital or non-Rural Health Center setting
- Treatment within six months of an accidental injury to repair or replace natural teeth or within six months of the effective date of coverage, whichever is later
- Repairing or replacing dental Prostheses caused by an accidental bodily injury within six months of the injury or within six months of the effective date of coverage, whichever is later.

Services for accidental injuries relating to biting and chewing are not covered.

Diabetic Services We provide Benefits for diabetes medication, equipment, and supplies which are medically appropriate and necessary. Benefits are limited to: insulin, insulin pumps, oral hypoglycemic agents, glucose monitors, test strips, syringes, lancets, and Outpatient self-management and educational services used to treat diabetes if services are provided through a program that is authorized by the State's Diabetes Control Project within the Maine Bureau of Health.

Diagnostic Services We provide Benefits for Diagnostic Services, including diagnostic laboratory and pathology tests (such as blood tests) and x-rays, when they are ordered by a Provider to diagnose specific signs or symptoms of an illness or injury or when the services are part of well-baby or well-adult care stated as covered under this contract. Benefits are also provided for genetic tests, when allowed by us.

You must receive prior authorization from us for the diagnostic services which include but are not limited to: CT Scans, MRI/MRAs, Nuclear Cardiology, and PET Scans.

Please call the number on the back of your Identification Card if you have questions regarding which services require prior authorization.

Durable Medical Equipment and Prostheses If more than one treatment, prosthetic device, or piece of Durable Medical Equipment may be provided for your disease or injury, Benefits will be based on the least expensive method of treatment, device, or equipment that can meet your needs. These terms apply to the following services:

Durable Medical Equipment We provide Benefits for the rental or purchase of Durable Medical Equipment. Whether you rent or buy the equipment, we provide Benefits for the least expensive equipment necessary to meet your medical needs. If you rent the equipment, we will make monthly payments only until our share of the reasonable purchase price of the least expensive equipment is paid or until the equipment is no longer necessary, whichever comes first.

Benefits for replacement or repair of purchased Durable Medical Equipment are subject to our approval. We do not provide Benefits for the repair or replacement of rented equipment.

Supplies are covered if they are necessary for the proper functioning of the Durable Medical Equipment.

Prostheses We provide Benefits for Prostheses. Prostheses include artificial limbs and prosthetic appliances. Please refer to the "Exclusions" section for additional information.

Early Intervention Services We provide benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child's primary care provider is required.

Please refer to your Schedule of Benefits for limits that may apply.

Emergency Room Care We provide Benefits for emergency room treatment received for medical emergencies once you pay the emergency room Copayment listed on your Schedule of Benefits. You or a designated person should contact your Physician within 48 hours from the time you receive care.

If you are admitted to the Hospital from the emergency room, the emergency room Copayment is waived. You or a designated person should contact your Physician within 48 hours from the time you are admitted. If you do not contact your Physician, you or someone you designate should call the telephone number listed on your ID card within 48 hours of admission.

Eye Examinations We provide benefits for one annual routine eye examination for vision correction. Eye examinations related to a diagnosed medical condition are covered as often as needed regardless of age. If your plan has separate Vision Coverage, the exam will be covered under that plan.

Family Planning We provide Benefits for family planning. See the 'Contraceptives' provision within this section for details.

Foot Care We provide Benefits for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Freestanding Imaging Centers We provide Benefits for Diagnostic Services performed by Freestanding Imaging Centers. All services must be ordered by a Provider.

Hearing Care We provide benefits for wearable hearing aids for covered Members through age 18. Coverage is limited to one hearing aid for each hearing-impaired ear every 36 months. Related items such

as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing.

Home Health Care Services We provide Benefits for home health care services when services are performed and billed by a home health care agency. A home health care agency must submit a written plan of care, and then provide the services as approved by us.

We provide Benefits for the following home health care services:

- Physician home and office visits;
- Registered nurse (RN) or licensed practical nurse (LPN) nursing visits;
- Services of home health aides when supervised by an RN;
- Paramedical services, including physical therapy, speech therapy, occupational therapy, inhalation therapy, and nutritional guidance;
- Supportive services, including Prescription Drugs, medical and surgical supplies, and oxygen.

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Abuse Services" section below.

Hospice Care Services

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may also access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. See below for details on respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

We provide Benefits for Hospice Care services by a Home Health Agency up to 24 hours during each day of care. Hospice Care services are provided according to a written care delivery plan developed by a Hospice Care Provider and the recipient of Hospice Care services. Prior approval is required when care exceeds eight hours a day. In this case, the agency must submit a plan of care to receive approval. The agency must then submit a plan of care every 14 days to maintain approval. To be eligible for Hospice Care services, the patient need not be homebound or require skilled nursing services. Coverage for Hospice Care services is provided in either a home or Inpatient setting.

Hospice Respite Care We provide Benefits for up to a 48-hour period for respite care. Respite care is intended to allow the person who regularly assists the patient at home, either a family member or other nonprofessional, to have personal time solely for relaxation. The patient may then need a temporary replacement to provide Hospice Care.

Before the patient receives respite care at home, a Home Health Agency must submit a plan of care for approval. Prior approval is also required when respite care is provided by an Inpatient Hospice.

Inborn Errors of Metabolism We provide Benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by Inborn Error(s) of Metabolism. This benefit is limited to those Members with diseases caused by Inborn Error(s) of Metabolism.

Independent Laboratories We provide Benefits for Diagnostic Services performed by independent laboratories. All services must be ordered by a Provider.

Infant Formula We provide Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.

Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Infusion Therapy We provide Benefits for infusion therapy when services are provided by a licensed Provider, facility, ambulatory infusion center, or home infusion therapy provider, as appropriate. Supplies and equipment needed to appropriately administer infusion therapy are covered.

Inhalation Therapy We provide Benefits for inhalation therapy by a licensed therapist for the administration of medications; gases such as oxygen, carbon dioxide, or helium; water vapor; or anesthetics.

Inpatient Hospital Services We provide Benefits for the following Inpatient Hospital services:

- Room and board, including general nursing care, special duty nursing, and special diets, in a semiprivate room or a private room when medically necessary or when the facility offers only private rooms;
- Use of intensive care or coronary care unit;
- Diagnostic Services;
- Medical, surgical, and central supplies;
- Treatment services;
- Hospital ancillary services including but not limited to use of operating room, anesthesia, laboratory, x-ray, occupational therapy, physical therapy, speech therapy, inhalation therapy, and radiotherapy services;
- Phase I Cardiac Rehabilitation;
- Medication used when you are an Inpatient, such as drugs, biologicals, and vaccines. This does not include the use of drugs for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS unless approved by us for medically necessary accepted indications or as required by law. Any FDA Treatment Investigational New Drugs are not covered unless approved by us for medically accepted indications or as required by law;
- Blood and blood derivatives;
- Prostheses or Orthotic Devices;
- Newborn care, including routine well-baby care.

Benefits for an Inpatient Stay in a Hospital will end with the earliest of the following events:

- You are discharged as an Inpatient;.
- You reach any of the limits or maximums shown in your Schedule of Benefits;
- Your Physician, Hospital personnel, or we notify you that Inpatient care no longer meets our guidelines for continued Hospital admission.

Manipulative Therapy We provide Benefits for treating acute musculo-skeletal disorders. No Benefits are provided for ancillary treatment such as massage therapy, heat, and electrostimulation unless in conjunction with an active course of treatment. Benefits are not provided for Maintenance Therapy for chronic conditions. Please see your Schedule of Benefits for limits that apply.

Massage Therapy We provide Benefits for massage therapy when services are part of an active course of treatment and the services are performed by a Covered Provider (Please see definition of Covered Provider.). A massage therapist is not a Covered Provider.

Medical Care We provide Benefits for medical care and services including office visits and consultations, Hospital and Skilled Nursing Facility visits, and pediatric services.

Medical Supplies We provide Benefits for medical supplies furnished by a Provider in the course of delivering medically necessary services. This benefit does not apply to bandages and other disposable items that may be purchased without a prescription, except for syringes which are medically necessary for injecting insulin or a drug prescribed by a Physician.

Mental Health and Substance Abuse Services We provide Benefits for only the following Mental Health and Substance Abuse services when they are for the active treatment of Mental Health and Substance Abuse disorders. These services must be part of an established plan of treatment and must be performed and independently billed by a Provider acting within the scope of his or her license.

Benefits for Inpatient, Outpatient, and day treatment services for Mental Health and Substance Abuse are provided when you receive them from a Provider. You will receive maximum Benefits for Mental Health and/or Substance Abuse Services when you receive care from Network Providers.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- **Online Visits** when available in your area. Covered Services include a visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a physician weekly or more often,
  - Rehabilitation, therapy, and education.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or

Any agency licensed by the state to give these services, when we have to cover them by law.

If you receive Provider services from a Community Mental Health Center or Substance Abuse Treatment Facility, services must be:

- Supervised by a licensed Physician, licensed clinical psychologist, licensed clinical professional counselor, or licensed clinical social worker; and
- Part of a plan of treatment for furnishing such services established by the appropriate staff member.

You will receive maximum Benefits for Mental Health and/or Substance Abuse services when you receive care from Network Providers.

- Individual and group counseling;
- Family counseling;
- Psychological testing;
- Diagnostic and evaluation services;

- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring an immediate and acute need for treatment;
- Intervention and assessment;
- Room and board, including general nursing;
- Prescription Drugs, biologicals, and solutions administered to Inpatients;
- Supplies and use of equipment required for detoxification and rehabilitation;
- Diagnostic and evaluation services;
- Intervention and assessment;
- Facility-based professional and ancillary services;
- Individual, Group and family counseling;
- Psychological testing;
- Emergency treatment for the sudden onset of a Mental Health or Substance Abuse condition requiring immediate and acute treatment.

The "Utilization Management" section contains additional information about seeking Mental Health and Substance Abuse services. Please refer to your Schedule of Benefits for additional information regarding Mental Health and Substance Abuse Benefits.

Morbid Obesity We provide limited Benefits for treatment of Morbid Obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits are limited to surgery for an intestinal bypass, gastric bypass, or gastroplasty. Prior authorization is required. We do not provide Benefits for weight loss medications.

Nutritional Counseling We provide Benefits for nutritional counseling when required for a diagnosed medical condition.

Obstetrical Services and Newborn Care We provide Benefits for prenatal, postnatal and postpartum care, delivery of a newborn, care of a newborn, and complications of pregnancy. Benefits are provided for routine circumcisions.

Office Visits and Doctor Services

Covered Services include:

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

Retail Health Clinic Care for limited basic health care services to Members without an appointment. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor's Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor's office.

Urgent Care / Walk-In Center Services as described in "Urgent Care / Walk-In Center Services" later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test

results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Please refer to the "Telemedicine" provision as you may have additional or different services available. For Mental Health and Substance Abuse Online Visits, see the Mental Health and Substance Abuse Services section.

Prescription Drugs Administered in the Office as described in the "Prescription Drugs Administered by a Medical Provider" later in this section.

Please refer to the "Telemedicine" provisions as you may have additional or different services available.

Organ and Tissue Transplants We provide Benefits for organ and tissue transplant procedures listed below. You must receive prior approval from us before you are admitted for any transplant procedure. Your Physician will work with our registered nurses and Physician advisors to evaluate your condition and determine the medical appropriateness of a transplant procedure. Failure to receive approval prior to admission may result in a denial or reduction of Benefits.

Transplants include:
heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney, cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

No other organ or tissue transplant is covered. We will not pay any Benefits for any services related to a transplant we do not cover.

We provide Benefits as follows:
- If both the donor and the recipient are covered Members of ours, we will provide Benefits to cover both patients for organ and tissue transplants;
- If the recipient is a Member under a Contract with us but the donor is not, we will provide Benefits for both the recipient and donor as long as similar Benefits are not available to the donor from other sources;
- If the recipient is not a Member under a Contract with us but the donor is a Member, we will not provide Benefits to either the donor or the recipient.

Coverage for the cost of testing for bone marrow donation suitability

The Plan provides coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The covered member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;

C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

This benefit is limited to one test per lifetime.

Orthotic Devices We provide Benefits for certain types of orthotics (braces, boots, splints). Covered Services include only the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device (or necessary replacement if unable to repair) used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Outpatient Services We provide Benefits for the following Hospital Outpatient and Rural Health Center services:

- Emergency room services/emergency care;
- Removal of sutures;
- Application or removal of a cast;
- Diagnostic Services;
- Surgical Services;
- Removal of impacted or unerupted teeth;
- Endoscopic procedures;
- Blood administration;
- Radiation Therapy;
- Outpatient rehabilitation programs including covered Phase II cardiac rehabilitation, physical rehabilitation, head injury rehabilitation, pulmonary rehabilitation, and dialysis training. Benefits for these services have special requirements. Please check with us to see if you are eligible for Benefits;
- Outpatient educational programs such as diabetes education. Please check with us to see if you are eligible for benefits.

Parenteral and Enteral Therapy We provide Benefits for parenteral and enteral therapy. Supplies and equipment needed to appropriately administer parenteral and enteral therapy are covered. Nutritional supplements for the sole purpose of enhancing dietary intake are not covered unless they are given in conjunction with enteral therapy.

Physical and Occupational Therapy We provide Benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined Calendar Year limit as described on your Schedule of Benefits. Services are covered only when provided by a licensed Provider acting within the scope of his/her license.

No Benefits are provided for treatments such as: massage therapy, paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section.

Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage
Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

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

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

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

If precertification is denied you have the right to file an Appeal as outlined in the "Benefit Determinations, Payments and Appeals" section of the Certificate of Coverage.

Designated Pharmacy Provider
Anthem may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription

Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug if such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the out of network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at {www.anthem.com}.

Continuity of Prescription Drugs
The Plan reserves the right to request a review of your previous insurance carrier's prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier's prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

Therapeutic Substitution
Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

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

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

Prescription Drug Benefits
Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization
Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,

- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of a Prescription Drug List (as described below).

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

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

If prior authorization is denied you have the right to file an Appeal as outlined in the "Benefit Determination, Payment and Appeal" section of the Certificate of Coverage.

Covered Prescription Drugs
To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved prescribed contraceptives when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.

- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products With Therapeutic Equivalence Evaluations,* require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Where You Can Get Prescription Drugs

In-Network Pharmacy
You can visit one of the local Retail Pharmacies in our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to us with a written request for payment.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Complaints and Appeals" section of this Booklet.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single IN-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Complaints and Appeals" section of this Booklet.

Specialty Pharmacy
We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

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

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Choice} for Maintenance Drugs – If you are taking a Maintenance Medication, you may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if you would like to keep getting your Maintenance Medications from your local Retail Pharmacy or if you would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication you get without registering your choice each year through the Home Delivery Pharmacy. You can tell us your choice by phone at 888-772-5188 or by visiting our website at www.anthem.com

A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Maintenance Pharmacy
You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at **w**ww.anthem.com for more details.

Out-of-Network Pharmacy
You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. We will reimburse you based on the amount we would have paid to a participating Pharmacy less your share of the cost.

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

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

Prescription Drug List
We also have an Anthem Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

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

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List
If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision with 72 hours of receiving your request. IF the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan. We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug you have the right to request and external review by an IRO. The IRO will make a coverage decisions within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of your request or your Doctor's request for an exception will only be provided if you are a Member enrolled under the plan.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits
Certain day supply limits apply to Prescription Drugs. In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. As required by Maine law, one early refill for prescription eye drops may be available. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Half-Tablet Program
The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Therapeutic Substitution
Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program
The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled at the Specialty pharmacy. This program also saves you out of pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Special Programs
Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

Preventive and Well-Care Services
Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means

many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High Blood Pressure;
   Type 2 Diabetes Mellitus;
   Cholesterol;
   Child and Adult Obesity.

   Note: Coverage is provided for colorectal cancer screening for asymptomatic individuals 50 years of age or older, or less than 50 years of age and at high risk for colorectal cancer. Coverage also includes a colonoscopy when recommended as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Women's Preventive: Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
   - Women's contraceptives, sterilization procedures, and counseling: This includes Generic and single-source brand name drugs for oral contraceptives, as well as injectable contraceptives and patches at no cost share. Please use your Prescription Drug benefit when available. Contraceptive services such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Note: Multi-source brand drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the Prescription Drug benefit and apply the applicable cost share. For FDA-approved prescribed contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.
   - Breastfeeding support, supplies and counseling; Covered in full when received from an in-network provider.
   - Screenings and/or counseling, where applicable, for Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   - Counseling
   - Prescription Drugs
   - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
6. Prescription Drugs and OTC items identified as an A or B recommendation of the United States Preventive Services Task Force when prescribed by a Provider including:

   - Aspirin
   - Folic acid supplement
   - Vitamin D supplement
   - Bowel preparations

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

You may call Member Services using the number on your ID card for additional information about these services. (or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Covered Services also include these services as required by state law:

- Prostate Specific Antigen test and digital rectal examination for men

Radiation Therapy We provide Benefits for Radiation Therapy.

Reconstructive Surgeries, Procedures and Services Benefits are available for reconstructive surgeries, procedures and services, when considered to be Medically Necessary Health Care, only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. necessary due to accidental injury; or
2. necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary Health Care to restore or improve a bodily function, or
4. necessary to correct a birth defect for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate
5. for reconstruction of a breast on which mastectomy surgery has been performed and for surgery and reconstruction of the other breast to produce a symmetrical appearance when the mastectomy is for the treatment of breast cancer.

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Certificate.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

1) Mastectomy for Gynecomastia
2) Mandibular/Maxillary orthognathic surgery
3) Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants

4) Port Wine Stain surgery

Skilled Nursing Facility Services We provide Benefits for Inpatient Skilled Nursing Facility services. We do not cover custodial confinement.

Smoking Cessation We provide Benefits for nicotine replacement therapy (NRT) products and any other medication specifically approved by the FDA for smoking cessation. To be eligible for Benefits, these products and medications must be prescribed by your Physician.

- NRT products can include but are not limited to, nicotine patches, gum, or nasal spray.
- We provide Benefits for follow-up smoking cessation education and counseling.
- We provide Benefits for completing an approved smoking cessation program.

Please see your Schedule of Benefits for applicable Copayment, Coinsurance, Deductibles, limitations, and maximums that apply.

Speech Therapy We provide Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement. Benefits are subject to a combined Calendar Year limit as described on your Schedule of Benefits. Services are covered only when provided by a licensed Provider acting within the scope of his/her license.

No Benefits are provided for:

- Deficiencies resulting from mental retardation; or
- Dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Sterilizations We provide benefits for sterilization services.

Surgical Services Benefits are provided for covered surgical procedures, including services of a surgeon, specialist, anesthetist or anesthesiologist, and for preoperative and postoperative care.

For covered surgeries, services of surgical assistants are payable as a surgery benefit if included on the list of payable Anthem surgical assistant codes. If you have questions about your surgical procedure, please contact your physician or Customer Service.

Telemedicine Benefits are provided for telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a covered health care provider. Coverage for health care services provided through telemedicine will be determined in a manner consistent with coverage for health care services provided through in-person consultation.

Urgent Care / Walk-In Center Services

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

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;

- Stitches for simple cuts; and
- Draining an abscess.

Varicose Vein Surgery Benefits are provided for medically necessary varicose vein surgery. Cosmetic surgery is not covered.

Section Four
Exclusions

This section, along with the "Covered Services" section, explains the types of health care services we will and will not provide Benefits for. The exclusions listed below are in addition to those set forth elsewhere in this Certificate. Charges you pay for services related to non-Covered Services do not count toward any Deductible, Coinsurance, or out-of-pocket limits.

Acupuncture We do not provide benefits for acupuncture.

Alternative Medicines or Complementary Medicines We do not provide Benefits for alternative or complementary medicine. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established, as determined by Anthem's Medical Director. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless otherwise stated in the Covered Services section), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under Autism Services in the "Covered Services" section unless otherwise required by law.

Asthma Education We do not provide benefits for asthma education programs.

Benefits Available from Other Sources We do not provide Benefits for any services to the extent that there is no charge to you or to the extent that you can recover expenses through a federal, state, county, or municipal law. This is the case even if you waive or fail to assert your rights under these laws. However, this exclusion does not apply to Medicaid.

Biofeedback We do not provide benefits for biofeedback.

Blood We do not provide Benefits for any blood, blood donors, or packed red blood cells when participation in a voluntary blood program is available.

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

Commercial Weight Loss Programs Weight loss programs not approved by us, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate of Coverage.

This exclusion includes, but is not limited to, commercial weight loss programs (for example Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to Medically Necessary treatments for morbid obesity.

Complications of/or Services Related to Non-Covered Services We do not provide Benefits for services, supplies, or treatment related to or, for problems directly related to a service that is not covered by

this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

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

Cosmetic Services We do not provide Benefits for treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

Custodial Care We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider**.**

Dental Services We do not provide Benefits for Orthognathic Surgery, dentistry, dental surgery, dental implants or any other services unless specifically listed as covered in the "Covered Services" section.

Department of Veterans Affairs We do not provide Benefits for any treatments, services, or supplies provided to veterans by the Department of Veterans Affairs, its Hospitals, or facilities if the treatment is related to your service connected disability.

Drugs Contrary to Approved Medical and Professional Standards Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

Drugs Over Quantity or Age Limits Drugs which are over any quantity or age limits set by the Plan or us

Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem

Experimental/Investigational Services We do not provide Benefits for any drugs, supplies, Providers, medical, or health care services that are Experimental or Investigational. This exclusion includes the cost of all services from a Provider including the cost of all services while you are an Inpatient receiving an Experimental or Investigational service or surgery. Drugs classified as Treatment Investigational New Drugs (IND) by the FDA and devices with the FDA Investigational Device Exemption (IDE), any device to which the FDA has limited access or otherwise limited approval, and any services involved in clinical trials are considered Experimental or Investigational.

Facilities of the Uniformed Services We do not provide Benefits for any treatments, services, or supplies provided by or through any health care facility of the uniformed services. This exclusion does not apply if you are a military dependent or retiree.

Family Planning Services We do not provide Benefits for services to reverse voluntarily induced sterility; non-prescriptive birth control preparations (such as foams or jellies); and over-the-counter contraceptive devices.

Food or Dietary Supplements We do not provide Benefits for nutritional and/or dietary supplements, except as provided in this Certificate of Coverage or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

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

Government Institutions We do not provide Benefits for any services provided to you by any institution that is owned or operated by the federal government or any state, county, or municipal government.

Health Club Memberships We do not provide Benefits for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Hearing Care We do not provide Benefits for hearing examinations except for screening Members under the age of 19 years or when related to injury or disease. Please see Hearing Care in the Covered Services section for benefits for hearing aids.

Infertility We do not provide Benefits for Diagnostic Services, procedures, treatment or other services related to Infertility. This exclusion also applies to drugs used to enhance fertility. We do not provide Benefits for costs associated with achieving pregnancy through surrogacy.

Leased Services and Facilities We do not provide Benefits for any health care services or facilities that are not regularly available in the Provider you go to, that the Provider must rent or make special arrangements to provide, and that are billed independently.

Maintenance Therapy Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.

Major Disaster, Epidemic, or War In the event of a major disaster, epidemic, war (declared or undeclared), or other circumstances beyond our control, we will make a good faith effort to provide or arrange for Covered Services. We will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel. Benefits are not provided for any disease or injury that is a result of war, declared or undeclared, or any act of war.

Massage Therapy We do not provide Benefits for massage therapy when services are not part of an active course of treatment and are not performed by a Covered Provider (Please see definition of Covered Provider.). Services by a massage therapist are not covered.

Medical Equipment, Devices, and Supplies

a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
c) Non-Medically Necessary enhancements to standard equipment and devices.
d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

Medicare We may not provide Benefits in situations where Medicare would have primary liability for health care costs under federal Medicare Secondary Payor regulations. If you are enrolled in Medicare Part A and/or Part B, and Medicare is the primary payor, we may provide Benefits only for balances remaining after Medicare has made payment. If you are eligible for premium free Medicare Part A, and Medicare would be the primary payor, we may pay Benefits as if Medicare had made their primary payments for Medicare Part A and/or Part B, even if you fail to exercise your right to premium free Medicare Part A coverage.

Mental Health, Substance Abuse Treatment and Lifestyle Services We do not provide Benefits for any of the following services or any services relating to:

- Smoking clinics;
- Sensitivity training;
- Encounter Groups;
- Educational programs except as indicated in the "Covered Services" section;
- Marriage, guidance, and career counseling;
- Codependency;
- Adult Children of Alcoholics (ACOA);
- Pain control (except as required by law for Hospice Care services);
- Activities whose primary purpose is recreational and socialization.

Miscellaneous Expenses We do not provide Benefits for Provider charges to provide required information to process a claim or application for coverage. We do not provide Benefits for any additional costs associated with an Appeal of a claim decision.

Missed Appointments We do not provide Benefits for missed appointments. Providers may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are available for these charges. You are solely responsible for these charges.

Non-Approved Drugs Drugs not approved by the FDA.

Non-Medically Necessary Services We do not provide Benefits for services we conclude are not Medically Necessary and do not meet the definition of Medically Necessary Health Care. This includes services that do not meet our medical policy, clinical coverage, or benefit policy.

Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

Orthognathic Surgery We do not provide Benefits for Orthognathic Surgery, except as stated in the Covered Services, Reconstructive Surgeries, Procedures and Services section.

Orthotic Devices We do not provide Benefits for Orthotic Devices unless stated as covered in the "Covered Services" section of this Contract.

Personal Comfort Items We do not provide Benefits for any personal comfort items such as television rentals, newspapers, telephones, and guest meals.

Physical and Occupational Therapy We do not provide Benefits for massage therapy, treatment such as paraffin baths, hot packs, whirlpools, or moist/dry heat applications unless in conjunction with an active course of treatment.

Prescription Drugs

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges or pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records
3. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.
   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
4. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **Delivery Charges** Charges for delivery of Prescription Drugs.
6. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

11. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
12. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
13. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. **Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
15. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
16. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the prescription drug benefit at a retail or home delivery (Mail Order) Pharmacy benefit may be covered under the Durable Medical Equipment and Medical Devices benefit. Please see that section for details.
17. **Items Covered for allergy testing and injections -** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the medical benefit. .
18. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
19. **Non-approved Drugs** Drugs not approved by the FDA.
20. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary and do not meet the definition of Medically Necessary Health Care. This includes services that do not meet our medical policy, clinical coverage, or benefit policy
21. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist
22. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it. Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
23. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
24. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
25. **Sanctioned or Excluded Providers** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
26. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
27. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Preventive Care We do not provide Benefits for preventive care and well-care services, unless otherwise stated in the "Covered Services" section.

Prostheses We do not provide Benefits for dental Prostheses, or prosthetic devices to replace, in whole or in part, an arm or a leg that are designed exclusively for athletic purposes.

Refractive Eye Surgery We do not provide Benefits for refractive eye surgery, such as radial keratotomy, for conditions that can be corrected by means other than surgery.

Residential Accommodations Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center. This exclusion includes procedures, equipment, services or charges for the following:

a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility hoe for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
c) Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
d) Wilderness camps.

Reverse Sterilizations We do not provide benefits for services to reverse voluntarily induced sterility.

Routine Foot Care We do not provide Benefits for any services rendered as part of routine foot care.

Routine Physicals and Immunizations We do not provide Benefits for Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

Sanctioned or Excluded Providers Any service, Drug, Drug regimen, treatment or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

Services After Your Contract Ends We do not provide Benefits for services that are provided after your Contract ends unless your Group cancels coverage with Anthem BCBS and you are an Inpatient on the Group cancellation date. If you are an Inpatient on the date your Group cancels coverage with Anthem BCBS and you have care after the date your Group coverage ends and your Group has replacement coverage, the replacement carrier pays primary benefits for the Inpatient care provided after the effective date and this Plan pays secondary Benefits. If there is no replacement carrier, this Plan pays primary Benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any Contract maximums, when you are discharged as an Inpatient and you are no longer disabled, or six months from the termination of your Group Contract, whichever occurs first.

Services Before the Effective Date We do not provide Benefits for any treatment, services, supplies, medical equipment, or Prostheses rendered to you or received before your individual effective date of coverage. Services you receive during an Inpatient Stay that started before you enrolled are covered only as of your effective date on this Contract. For an Inpatient Stay, care that is provided before your effective date is not covered.

Services by Ineligible Providers We do not provide Benefits for services received from an individual or entity that is not licensed by law to provide Covered Services as defined in this Certificate. Examples may include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

Services by Relatives or Volunteers We do not provide Benefits for any services provided in any capacity by immediate family members or step-family members, for example, spouse, father, mother, brother, sister, son or daughter. We do not provide Benefits for services by volunteers, except as outlined in the "Hospice Care Services" provision.

Services Not Listed As Covered We do not provide Benefits for any service, procedure, or supply not listed as a Covered Service in this Contract.

Shoe Inserts We do not provide benefits for foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

Speech Therapy We do not provide Benefits for deficiencies resulting from mental retardation and/or dysfunctions that are self-correcting, such as language treatment for young children with natural dysfluency or developmental articulation errors.

Surrogate Mother Services We do not provide Benefits for any services or supplies provided to a person not covered under the Certificate of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Temporomandibular Joint (TMJ) Syndrome Services We do not provide Benefits for surgical and non-surgical examination; diagnosis, including invasive (internal) and non-invasive (external) procedures and tests; and all services related to diagnosis and treatment, both medical and surgical, of temporomandibular joint dysfunction or syndrome also called myofascial pain dysfunction or craniomandibular pain syndrome. Examples of non-Covered Services include but are not limited to: physiotherapy, such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation; vapocoolant sprays, ultrasound, or diathermy; behavior modification such as biofeedback, psychotherapy; appliance therapy such as occlusal appliances (splints) or other oral Prosthetic Devices and their adjustments; orthodontic therapy such as braces; prosthodontic therapy such as crowns, bridgework; and occlusal adjustments.

This exclusion does not apply to services listed as covered in the "Dental Services" provision.

Travel Expenses We do not provide Benefits for any travel expenses, whether or not the travel is recommended by a Provider.

Vision Care We do not provide Benefits for vision therapy, including treatment such as vision training, orthoptics, eye training, or eye exercises. We do not provide Benefits for the prescription, fitting, or

purchase of glasses or contact lenses except when medically necessary to treat accommodative strabismus, cataracts, or aphakia.

Waived Cost-Shares Out-of-Network We do not provide Benefits for any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

Workers' Compensation We do not provide Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met**:

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan, as discussed in the "Benefit Determinations, Payments and Appeals" section.

Section Five
Benefit Determinations, Payments and Appeals

Benefit Determinations

We, or anyone acting on our behalf, shall determine the administration of Benefits and eligibility for participation in such a manner that has a rational relationship to the terms of the Contract. However, We, or anyone acting on our behalf, have complete discretion to determine the administration of your Benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Investigational/Experimental, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowed Amount. However, you may utilize all applicable Complaint and Appeal procedures, as outlined later in this section.

You may have some responsibility for the cost of health services under your Contract. Your responsibility may take the form of a Coinsurance percentage, a Deductible, or a Copayment amount. Please see your Schedule of Benefits for the Coinsurance, Deductible and Copayment amounts that apply to your coverage. If you have some responsibility for the cost of health care services you receive, you will pay your Coinsurance, Deductible, or Copayment amount directly to the Provider or Hospital or other provider of care. If you have Coinsurance responsibility that is based on a percentage, you will pay your Coinsurance percentage based on the Hospital's or Provider's discounted charge or negotiated amount, or our Maximum Allowed Amount for Providers.

Under certain circumstances, if we pay the healthcare provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Note: We cannot prohibit Non-Network Providers from billing you for the difference in their charge and our Maximum Allowed Amount.

All Benefits for Covered Services will be based on any discounted charge for Hospital service or our Maximum Allowed Amount for Providers services.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include, but is not limited to, Prescription Drugs, Mental Health, behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Benefit Levels There are two levels of Benefits under this Contract:

Network Providers If your claim from a Network Provider is approved, we will pay Benefits directly to the Network Provider. Except for Copayments, Deductibles, and Coinsurance, you are not required to pay any balances to the Provider for Covered Services until after we determine the Benefits we will pay. Benefits will be paid at the Network level of Benefits listed on your Schedule of Benefits.

Non-Network Providers If you receive Covered Services or supplies from a Provider that does not have a written agreement with us, we will determine Benefits based on the Provider's eligibility and licensing. If we do approve your claim, Benefits will be paid at the Non-Network level of Benefits listed on your Schedule of Benefits. You will be responsible for the difference between the Non-Network Provider's charge and our Maximum Allowed Amount, in addition to any applicable Copayment or Deductible. We cannot prohibit Non-Network Provider's from billing you for the

difference in their charge and our Maximum Allowed Amount. If a Network Provider of the same specialty is not reasonably accessible, as defined by state law, services received from a Non-Network Provider will be paid at the higher level of Benefits indicated on your Schedule of Benefits. In this circumstance, please call the number on the back of your ID card to coordinate care through a Non-Network Provider.

How Your Deductible Works

Each Calendar Year before Benefits can be paid for most Covered Services, you must pay your Deductible. Please refer to your Schedule of Benefits.

Family Deductible Under family coverage, if the total family expenses for Covered Services exceed two times the individual Deductible, then your family Deductible under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without meeting further Deductibles. One family member may not meet the family Deductible amount. The family Deductible amount must be satisfied by at least two family members.

One Deductible For a Common Accident Under family coverage, if two or more family members are injured in the same accident, only one Deductible will apply for all Covered Services resulting from that accident during a Calendar Year.

Copayments and Coinsurance

Copayments and Coinsurance apply after you have satisfied your Deductible. Please see your Schedule of Benefits for Copayment amounts and Coinsurance amounts and limits. If services are received from a Provider that does not have a written participation agreement with us there may be instances in which you may be responsible for any remaining balances beyond the Maximum Allowed Amount in addition to any applicable Copayment, Coinsurance or Deductible. We cannot prohibit Non-Network Providers from billing you for the difference in their charge and our Maximum Allowed Amount.

Copayments

For some services, your share of the cost is a fixed dollar amount or a percentage. Copayment amounts do count toward the Coinsurance and Out-of-Pocket limits under this Contract. Please see your Schedule of Benefits for applicable Copayment amounts.

Coinsurance For some services, your share of the cost is a percentage which is limited to an annual dollar amount. This is the Coinsurance amount. Once you pay the annual Coinsurance limit, we pay Benefits at 100% of the Maximum Allowed Amount for Covered Services, for the rest of the Calendar Year.

How Your Coinsurance Limit Works Under family coverage, if the total family Coinsurance expenses exceed two times the individual Coinsurance limit, your family Coinsurance limit under this Contract has been met for the Calendar Year. In this case, all family members will be eligible for Benefits for the rest of the Calendar Year without paying further Coinsurance.

Out-of-Pocket Limits

Your annual out-of-pocket expenses for your Copayments, Deductible and Coinsurance are limited. Please refer to your Schedule of Benefits for Annual Out-of-Pocket Limits that may apply. Once you reach the Annual Out-of-Pocket Limit, no further Copayments, Deductibles or Coinsurance apply for the remainder of the Calendar Year. The Out-of-Pocket Limit does not include your Subscription Charges, amounts over the Maximum Allowed Amount, services covered under any vision plan (if applicable), or charges for non-covered services.

Benefit Maximums

Specific benefit maximums for each covered Member may apply for Mental Health and other services. These maximums are listed on your Schedule of Benefits or in the Contract.

Contract Changes

We may change this Contract at any time provided the changes are in accordance with all applicable laws and we give the Group notice thirty days in advance. After we notify the Group of a change, payment of billed charges indicates the Group's and your acceptance of the change. The Group is responsible for notifying the employee of any Contract changes.

Compliance with Laws

If federal laws or the relevant laws of the state of Maine change, the provisions of this Contract will automatically change to comply with those laws as of their effective dates. Any provision that does not conform with applicable federal laws or the relevant laws of the state of Maine will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Confidentiality

Any information pertaining to your diagnosis, treatment or health obtained from either your Physician, Provider or you will be held in confidence. We may use or disclose this information only to the extent required or permitted by law. Please refer to Anthem BCBS's privacy protection annual notice for our privacy policies and procedures.

Statements and Representations

The statements you make on your application for coverage with us are representations and not warranties. No statement made by you for insurance shall avoid the insurance or reduce benefits thereunder unless contained in the written application for coverage signed by you.

Acknowledgement of Understanding

By accepting this policy you expressly acknowledge your understanding that this policy constitutes a benefit plan provided through your Group by agreement with Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The license permits Anthem to use the Blue Cross and Blue Shield service marks in the State of Maine, and that Anthem is not contracting as the agent of the Association.

You also acknowledge that you have not accepted this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem will be held accountable or liable to you for any of Anthem's obligations created under this policy. These acknowledgements in no way create any additional obligations whatsoever on the part of Anthem other than those set forth in this policy.

Annual Reports
Annual reports are prepared and made available to all employees. The annual report contains information about our activities including audited financial statements.

Severability
If any term or provision in this Certificate is deemed invalid or unenforceable, this does not affect the validity or enforceability of any other term or provision.

Benefit Payments

Claims Procedure:

How to Claim Benefits In most instances, Providers will file your claims with us. However, you may need to submit a claim for reimbursement for services from Non-Network Providers.

To receive claim forms, contact your employer or call our Customer Service Department. When you submit your claim, please include originals of all of your bills and retain a copy for your files.

Time Limit for Filing Claims We must receive proof of a claim for reimbursement for a Covered Service no later than 365 days after that service is received. We recognize that there may be special circumstances which would prevent a claim from being submitted within the 365-day time limit. Claims denied for timely filing may be reviewed through the Member Appeal process, which will consider whether the claim was filed as soon as reasonably possible.

Releasing Necessary Information Providers often have information we need to determine your coverage. As a condition for receiving Benefits under this Contract, you or your representative must give us all of the medical information needed to determine your eligibility for coverage or to process your claim.

Assignment
The benefits and rights you have under your contract with Anthem cannot be assigned by you by signing a form, by operation of law or by any other manner unless you get prior permission from Anthem in writing. The insured may assign benefits for care to the Provider of the care. An assignment of benefits does not affect or limit the payment of benefits otherwise payable under the Plan.

Non-Compliance If we do not enforce compliance with any provision of this Contract, we have not waived compliance and are not required to allow non-compliance of that provision or any other provision at any time, in any case.

Examination of Insured To ensure that all claims are valid, we may require the Member to have a physical or mental examination at our expense.

Claims Payment:

This section explains how benefits for covered services will be paid. We reserve the right to pay benefits to another person if so ordered by a court of competent jurisdiction. You have the right to appeal as outlined later in this section. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. Please contact the customer service department at the telephone number on your ID card for information on obtaining claim forms.

We will pay benefits for a claim under this policy or certificate within 30 days after proof of loss is received by us.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Payment of Provider Services

Maximum Allowed Amount

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on your Contract's Maximum Allowed Amount for the Covered Service that you receive. Please see Inter-Plan Arrangements later in this section for additional information.

The Maximum Allowed Amount for your Contract is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary Health Care; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant.

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

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

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

Provider Network Status
The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for your Contract is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Non-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

The Maximum Allowed Amount for your Contract will be one of the following as determined by Anthem:

1. An amount based on our network or non-network provider fee schedule/rate (as required by law), which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data or

2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare

and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this product, but contracted for other products with us are also considered Non-Network. For your Contract, the Maximum Allowed Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

Unlike Network Providers, Non-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Network Provider or visit our website at www.anthem.com.

Customer Service is also available to assist you in determining your Contract's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS: There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as coinsurance, copayments, and out of pocket maximums may be higher if you use a non-network provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact customer service for assistance.

Claims Review
Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

For Prescription Drugs: The Maximum Allowed Amount for prescription drugs is the amount determined by Anthem using prescription drug cost information provided by the pharmacy benefits manager (PBM).

Member Cost Share
For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Maximum may vary depending on whether you received services from a Network or Non-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Schedule of Benefits for your cost share responsibilities and limitations, or call Customer Service to learn how this Contract's benefits or cost share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-covered services. You will be responsible for the total amount billed by your Provider for non-covered services, regardless of whether such services are performed by a Network or Non-Network Provider. Both services specifically excluded by the terms of your plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower Network cost sharing amount when you use a Non-Network Provider. For example, if you go to a Network Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, you will pay the Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless Anthem has authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies or you receive a surprise bill, if applicable.

We and/or our designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Benefit Booklet and which positively impact the cost effectiveness of Covered Services. These amounts are retained by us. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance

Surprise Bill
The following only applies to Providers within the State of Maine:

A surprise bill is a bill for Covered Services, other than Emergency Services, received by a Member for services rendered by a Non-Network Provider at a Network Provider during a service or procedure performed by a Network Provider, or during a service or procedure previously approved or authorized by us; however, a surprise bill does not include a bill for Covered Services received by a Member if a Network Provider was available and the Member knowingly elected to obtain the services from a Non-Network Provider.

With respect to a surprise bill, a Member is only responsible for what the Member would have paid (any applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense) for a Network Provider. The Non-Network Provider within the State of Maine is prohibited by law from balance billing the Member.

Authorized Services
In some non-emergency circumstances, such as where there is no Network Provider available for the Covered Service, we may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. If we authorize a Covered

Service so that you are responsible for the Network cost share amounts, you will not be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Member Service for Authorized Services information or to request authorization.

Continuity of Care

If your In-Network Provider leaves our network because we have terminated their contract without cause, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. "Active treatment" includes:

1) An ongoing course of treatment for a life-threatening condition.
2) An ongoing course of treatment for a serious acute condition.
3) The second or third trimester of pregnancy; or
4) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care would worsen your condition or interfere with anticipated outcomes.

An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

Out-of-State Providers We cannot prohibit out-of-state Providers from billing you any balance remaining after we have made our payment based on the maximum allowable amount except as otherwise provided under the BlueCard program.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Program

We may offer health or fitness programs for purchase by your Group. These programs are separate and not part of your Group Health Plan, and are not guaranteed under your *insurance* Certificate and could be removed at any time. If your Group has chosen one of these options, You may receive incentives such as gift cards by being part of or completing such voluntary wellness programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by reaching specified goals based on health factors when done in accordance with state or federal law. However, if it is too difficult due to a medical condition for you to meet the standards for a reward under such a program, or if it is medically unwise for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Program Incentives

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

Payment Innovation Programs

We may pay In-network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by In-Network Providers to us under the Program(s).

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan / Employer on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

E. Nonparticipating Providers Outside Our Service Area

1. **Allowed Amounts and Member Liability Calculation**

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

2. **Exceptions**

   In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special

negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross (Blue Shield) Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross (Blue Shield) Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross (Blue Shield) Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Management" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross (Blue Shield) Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross (Blue Shield) Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross (Blue Shield) Global Core®; and
- Outpatient services.

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

When you need Blue Cross (Blue Shield) Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross (Blue Shield) Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

Hospitals Outside of the United States We provide Benefits for Inpatient and Outpatient services in a foreign Hospital. If you obtain Covered Services outside of the United States, in most cases you will have

to pay your bill when you leave the Hospital. Please refer to the "Utilization Management" section for details pertaining to authorizations.
When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for Covered Services according to the terms of this Contract.

Pharmacy Benefit Management

The Pharmacy Benefits available to you under this Plan are managed by a pharmacy benefits management (PBM) company with which we contract to manage your Pharmacy Benefits. The PBM has a nationwide network of retail pharmacies, a mail service Pharmacy, and clinical services that include tier management.

The management and other services provided include, among others, making recommendations to, and updating, the tier listing and managing a network of retail pharmacies and operating a mail service Pharmacy. The PBM, in consultation with Anthem, also provides services to promote and enforce the appropriate use of Pharmacy Benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

Payment for Prescription Drug Claims

To obtain Benefits for Prescription Drugs, present your identification card to any Pharmacy that has an agreement with the PBM, in this or any other state. You must pay the applicable amounts shown on your Schedule of Benefits. The participating Pharmacy will submit the claim for you and the PBM will directly pay the Pharmacy the balance due. Please call Customer Service at the telephone number on your ID card if you have questions about the participation status of a Pharmacy.

If you use a Pharmacy that does not have an agreement with the PBM, or if you do not use your identification card, you must pay the Pharmacy the entire cost for the prescription and submit a claim form for reimbursement. Claim forms are available by contacting a Customer Service Representative.

If you receive Prescription Drugs from a non-participating Pharmacy or if you do not use your identification card, you may receive a reduced benefit. We will reimburse you based on the amount we would have paid to a participating Pharmacy less your share of the cost.

Your financial responsibility (Copayments) will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Manager from drug manufacturers, or similar vendors or funds received by the plan from the Pharmacy Benefits Manager.

Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the Pharmacy or the Pharmacy Benefits manager that fills your prescription.

No payment will be made by us for any Covered Service unless our negotiated rate exceeds any applicable Copayment for which you are responsible.

For Prescription Drugs: The Maximum Allowed Amount for prescription drugs is the amount determined by Anthem using prescription drug cost information provided by the pharmacy benefits manager (PBM).

Prescription Drugs By Mail

To obtain Benefits for Prescription Drugs through the mail order Pharmacy, complete a mail order Pharmacy form, available through our Customer Service Department, and mail it with your prescription. You must enclose the applicable Copayment amount indicated on your Schedule of Benefits.

Coordination of Benefits

All Benefits of the Contract are subject to coordination of Benefits (COB). COB is a formula that determines how Benefits are paid to Members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total Benefits you receive from all contracts do not exceed the cost of Covered Services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-Group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid Group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for Covered Services as if there were no other coverage. The contract with secondary responsibility may provide Benefits for Covered Services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All Benefits are limited to the contract maximums or to the Maximum Allowed Amount for the services you receive.

The following are non-allowable expenses:

- The amount that is subject to the primary high-deductible health plan's deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

When you have duplicate coverage:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the Benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:

1. Non-Dependent/Dependent The Benefits of the contract that covers you as an employee or Subscriber will be determined before the Benefits of the contract that covers you as a Dependent are determined.
2. Dependent Children (Parents Not Legally Separated or Divorced) For claims on covered Dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of Benefits, the rule in this contract will determine the order of Benefits.
3. Dependent Children (Parents Legally Separated or Divorced) In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the Dependent's

health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.

4. Active/Inactive Employee The Benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's Dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's Dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of Benefits, rule six applies.
5. Continuation of Coverage If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or Subscriber, or as the Dependent of an employee or Subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
6. Longer/Shorter Length of Coverage If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or Subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Credit toward deductible

When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Disability

If your Group coverage terminates with us while you are totally disabled, Benefits for Covered Services directly relating to the condition causing total disability remain available to you until you are no longer disabled, you reach any contract maximums, you are discharged as an Inpatient and you are no longer disabled, or six months from the termination of your Group Contract, whichever occurs first. If you have replacement coverage, the replacement coverage will pay as primary coverage during this time, and we will pay as secondary coverage for the covered expenses directly relating to the condition causing total disability.

Under the Contract, disabled means:

- If you were employed, you are unable to work in your regular and customary occupation because of illness or injury;
- If you were not gainfully employed, you are unable to engage in most normal activities of a person of like age in good health.

Our coverage of losses during your total disability has the same limits that apply to employees or Members who are not disabled.

Special Information If You Become Eligible For Medicare

You must notify us if you become eligible for premium free Medicare Part A. Failure to notify us could result in retroactive benefit adjustments if Medicare would have been or is the primary payor. You may

choose to continue your coverage once you are eligible for premium free Medicare Part A and Medicare Part B coverage. However, your Contract will not provide Benefits that duplicate any benefits payable under Medicare Part A or Part B. This is true even if you fail to exercise your rights to premium free Medicare Part A and Medicare Part B coverage. If you become eligible for Medicare, you may want to enroll in a Medicare Supplement Plan. Medicare Supplement plans are specifically designed to pay many of the health care costs not covered by Medicare. Because Medicare Supplement plans have limited Enrollment Periods, it is important to evaluate these plans as soon as you are eligible for Medicare.

Third-Party Liability: Subrogation and Right of Reimbursement

These provisions apply when we provide health care Benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery from any source because of these injuries or illnesses. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreement characterize or allocate the money you receive as a Recovery, it shall be subject to these provisions. If the services related to your injuries or illness are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

Subrogation

We have a right to recover payments made on your behalf from any party responsible for compensating you for your injuries or illness, up to the total benefit we paid, on a just and equitable basis.

The following provisions apply:

- We have a lien against all or a portion of the benefits that have been paid to you from the following parties, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, you own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness.

- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them. If you have not pursued a claim against a third party allegedly at fault for your injuries by the date that is sixty (60) days before the date on which the applicable statute of limitations expires, We have a right to bring legal action against the at-fault party.

- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid.

Reimbursement

If you, a person who represents your legal interest, or a beneficiary or dependent have obtained a Recovery and We have not been repaid for the benefits We paid on your behalf, We have a right to be repaid from the Recovery up to the total benefit we paid, on a just and equitable basis. The following provisions apply:

- You must reimburse us to the extent of the health insurance benefits paid on your behalf from any Recovery, including but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of

the party or parties who caused the injuries or illness, you own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness;

- Upon receipt of a Recovery, You or your legal representative must immediately hold in trust the amount recovered in gross that is to be paid to us. The amount recovered in gross is the total amount of your Recovery reduced by your lawyer fees and costs.

Member's Duties

By accepting plan coverage you agree:

- Your signed application for coverage is your authorization of our rights of subrogation and reimbursement;
- To promptly notify us of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved;
- To cooperate with us in the investigation, settlement and protection of our rights;
- To cooperate with us in exercising our rights by providing all information requested, including copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury to you;
- To notify us if you retain counsel or file a legal action or claim against a third party;
- To notify us of any Recovery you receive as a result of legal action, a claim against a third party, or a claim against your own insurance within 60 days of your receipt of the Recovery.
- To sign documents we deem necessary to protect our rights; and
- To do nothing to prejudice or interfere with our rights.

If you do not comply with the above, we may request the courts to hold you responsible for expenses we incur in enforcing these provisions.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

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

Complaints and Appeals

Complaints

Our Customer Service Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Customer Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for us to reconsider an adverse determination within one working day after we get the request. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, we will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.

Anthem will make the decision within one working day after getting all needed information.
In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals.

Anthem has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process

You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by an appropriate peer or peers who have not been involved with a prior finding. More information may be submitted by or for the Member, any treating physician, or Anthem. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at **1-800-300-5000.**

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.

Level Two Appeal Process

On a level two appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem BCBS. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after we receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.
A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity, preexisting condition findings and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the Member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem BCBS did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem BCBS and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review. An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within two years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Section Six
Definitions

This section explains the meaning of some of the words in this Certificate. Other words may be defined in the text.

Accident Care Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

Ambulatory Surgery Center A facility that meets both of the following requirements:

- Licensed as an ambulatory surgery center, or is Medicare certified; and
- Meets our standards for participation.

Amendment An addition, change, correction, or revision to the terms and conditions of this Contract.

Annual Out-of-Pocket Limit The limit on the Copayments, Deductible and Coinsurance you pay each year. After you meet the Annual Out-of-Pocket Limit, you pay no further Copayments, Deductible or Coinsurance for the remainder of the calendar year.

Annual Review Date The date set by us and your Group on which the Contract renews each year.

Appeal A request for a review of our initial decision, a decision on a registered complaint, or determination of medical necessity.

Applied Behavior Analysis The design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Autism Spectrum Disorder Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefits Payments we make on your behalf under this Contract.

Biosimilar/Biosimilars A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

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

Calendar Year The period starting on the effective date of your coverage and ending on December 31 of that year or the date your coverage ends, whichever occurs first. Each succeeding Calendar Year starts on January 1 and ends on December 31 of that year or the date your coverage ends, whichever occurs first.

Certificate The document that specifies the health care Benefits available to Members under this Contract.

Chiropractor A person who is licensed to perform chiropractic services, including manipulation of the spine.

Coinsurance The percentage we pay toward the cost of some Covered Services and the percentage you pay.

Community Mental Health Center An institution that meets both of the following requirements:

- Licensed as a comprehensive level Community Mental Health Center; and
- Meets our standards for participation.

Contract This Certificate, any Amendments, riders, or attached papers; the Group Agreement; your application; and the Schedule of Benefits.

Contract Holder The employer, association, or trust that applies for and accepts this coverage on behalf of its Members.

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

Copayment A fixed dollar amount or percentage required to be paid by each Member for certain Covered Services under this Contract. Please refer to your Schedule of Benefits for specific information.

Cosmetic Services Medical/surgical procedures or services intended solely to change or improve appearance or to treat emotional, psychiatric, or psychological conditions.

Covered Service Services, supplies or treatment as described in this Certificate. To be a Covered Service the service, supply or treatment must be:

a. Medically Necessary or otherwise specifically included as a benefit under this Certificate.
b. Within the scope of the license of the Provider performing the service.
c. Rendered while coverage under this Certificate is in force.
d. Not Experimental or Investigational or otherwise excluded or limited by this Certificate, or by any Amendment or rider thereto.
e. Authorized in advance by us if such preauthorization is required in this Certificate.

Custodial Care Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;

- Suctioning;
- Using the toilet;
- Enemas; and
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial whether or not it is recommended or performed by a Provider and whether or not it is performed in a facility (e.g. Hospital or Skilled Nursing Facility) or at home.

Day Treatment Patient A patient receiving Mental Health or Substance Abuse care on an individual or Group basis for more than two hours but less than 24 hours per day in either a Hospital, rural Mental Health center, Substance Abuse Treatment Facility, or Community Mental Health Center. This type of care is also called partial hospitalization.

Deductible The amount you may be required to pay each year toward the Maximum Allowed Amount for certain Covered Services before this Contract provides Benefits.

Dental Service Items and services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth include: the periodontium, which includes the gingiva, dentogingival junction, cementum (the outer surface of a tooth root), alveolar process (the laminar dura, or tooth socket, and supporting bone), and the periodontal membrane (the connective tissue between the cementum and the alveolar process).

Dependent The eligible employee's lawful spouse, children and others as outlined in the "Eligibility, Termination and Continuation of Coverage" section of this Certificate.

Diagnostic Service A service performed to diagnose specific signs or symptoms of an illness or injury, such as: x-ray exams (other than teeth), laboratory tests, cardiographic tests, pathology services, radioisotope scanning, ultrasonic scanning, and certain other methods of diagnosing medical problems.

Discount Favorable rates or Discounts we have negotiated with Hospitals and other Providers. Members benefit from these rates or Discounts since they are applied prior to calculating your share of costs. discounted charges reduce the expenses paid by us which helps to lower the Contract costs.

Domiciliary Care Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Durable Medical Equipment Equipment that meets all of the following criteria:
- Can withstand repeated use;
- Is used only to serve a medical purpose;
- Is appropriate for use in the patient's home;
- Is not useful in the absence of illness, injury, or disease; and
- Is prescribed by a Physician.

Durable Medical Equipment does not include fixtures installed in your home or installed on your real estate.

Early Intervention Services Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36

months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Effective Date The first day of coverage with Anthem Blue Cross and Blue Shield.

Emergency Medical Condition A physical or mental condition, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the physical or Mental Health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to safely transfer to another Hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Service Health care services that are provided in an emergency facility or setting after the onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, that the absence of immediate medical attention could reasonably be expected by the prudent lay person, who possesses an average knowledge of health and medicine, to result in:

- Placing the Member's physical and/or Mental Health in serious jeopardy;
- Serious impairment to body functions; or
- Serious dysfunction of any body organ or part.

Examples of illnesses or conditions that may require Emergency Services include, but are not limited to: heart attack, stroke or severe hypertensive reaction, coma, blood or food poisoning, severe bleeding, shock, obstruction (airway, gastrointestinal or urinary tract), and allergic or acute reactions to drugs.

Enrollment Date The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Enrollment Period The period following your initial eligibility for enrollment.

Experimental or Investigational Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem BCBS determines to be Experimental or Investigational.

Anthem BCBS will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought.

(a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

(i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or

(ii) has been determined by the FDA to be contraindicated for the specific use; or

(iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or

(iv) is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or

(v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

(b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem BCBS. In determining whether a Service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection (c) and assess the following:

(i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;

(ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;

(iii) whether the evidence demonstrates the Service has been shown to be as beneficial for the total population for whom the Service might be proposed as any established alternatives; and

(iv) whether the evidence demonstrates the Service has been shown to improve the net health outcomes of the total population for whom the Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information considered or evaluated by Anthem BCBS to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:

(i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

(ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

(iii) documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(iv) documents of an IRB or other similar body performing substantially the same function; or

(v) consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vi) the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

(vii) medical records; or

(viii) the opinions of consulting Providers and other experts in the field.

(d) Anthem BCBS identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Facility A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.

Family Planning Agency An agency that meets both of the following requirements:

- Is a delegated Family Planning Agency under Title X of the Public Health Service Act and is in good standing with all applicable state and federal regulatory bodies; and
- Meets our standards for participation.

Freestanding Imaging Center An institution that meets both of the following requirements:

- Licensed (where available) as a Freestanding Imaging Center, freestanding diagnostic center, or freestanding radiology center; and
- Meets our standards for participation.

Freestanding Surgical Facility An institution that meets all of the following requirements:

- Has a medical staff of Physicians, nurses and licensed anesthesiologists;
- Maintains at least two operating rooms and one recovery room, as well as diagnostic laboratory and x-ray facilities;
- Has equipment for emergency care;
- Has a blood supply;
- Maintains medical records;
- Has agreements with Hospitals for immediate acceptance of patients who need Hospital confinement on an Inpatient basis;
- Is licensed in accordance with the law of the appropriate legally authorized agency; and
- Meets our standards for participation.

Generic Drugs Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grace Period The 31 days that begin with and follow the due date of an unpaid Subscription Charge.

Group The employer that applies for and accepts this coverage on behalf of its Members.

Home Health Agency An institution that meets both of the following requirements:

- Licensed as a Home Health Agency; and
- Meets our standards for participation.

Hospice A facility that meets both of the following requirements:

- Licensed as a Hospice; and
- Meets our standards for participation.

Hospice Care Services that furnish pain relief, symptom management, and support to terminally ill patients and their families.

Hospital An institution that is duly licensed by the state of Maine as an acute care, rehabilitation or psychiatric Hospital and is certified to participate in the Medicare program under Title XVIII of the Social Security Act.

Inborn Error of Metabolism A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Independent Laboratory An institution that meets both of the following requirements:

- Licensed as an independent medical laboratory; and
- Meets our standards for participation.

Infertility The inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the presence of a demonstrated condition recognized as a cause of Infertility by the American College of Obstetrics and Gynecology, the American Urologic Association, or other appropriate independent professional associations.

Inpatient A registered bed patient who occupies a bed in a Hospital, Skilled Nursing Facility, or residential treatment facility. A patient who is kept overnight in a Hospital solely for observation is not considered a registered Inpatient. This is true even though the patient uses a bed. In this case, the patient is considered an Outpatient.

Inpatient Stay One period of continuous, Inpatient confinement. An Inpatient Stay ends when you are discharged from the facility in which you were originally confined. However, a transfer from one acute care Hospital to another acute care Hospital as an Inpatient when medically necessary is part of the same stay.

Intensive In-Home Behavioral Health Program A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

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

Interchangeable Biologic Product A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollee A Subscriber or a Dependent family member who requests enrollment under the Contract Holder's Group health plan following the initial Enrollment Period provided under the terms of the plan; or a Subscriber or Dependent family member who enrolls after 31 days following any of the qualifying life events described in the "Eligibility, Termination, and Continuation of Coverage" section of this Contract. A Late Enrollee may only submit an application during the annual Late Enrollee Enrollment Period.

Maintenance Medications Please see the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy section for details.

Maintenance Therapy Any treatment, service, or therapy that preserves the Member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowed Amount The maximum amount that we will allow for Covered Services you receive. For more information, see the "Benefit Determinations, Payments and Appeals" section.

Medicaid Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary Health Care Health care services or products provided to a Member for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Member or Physician or other health care practitioner.

Medicare The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member The Subscriber and all family members who are eligible for coverage and who we accept for coverage under this Contract.

Mental Health and Substance Abuse
A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Morbid Obesity A condition of persistent and uncontrolled weight gain existing for a minimum of five consecutive years that constitutes a present or potential threat to life. This is characterized by weight that is at least 100 pounds over or twice the weight for frame, age, height, and sex in the most recently published Metropolitan Life Insurance table.

Network Pharmacy Any Pharmacy, located within the United States, acceptable as a Participating Pharmacy by Anthem to provide Covered Drugs to Members under the terms and conditions of this Certificate**.** Also referred to as "Participating Pharmacy".

Network Provider A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is in a Network for one plan may not be in Network for another.

Network Specialty Pharmacy Any appropriately licensed Pharmacy located within the United States which has entered into a contractual agreement with Anthem, or its pharmacy benefits manager designee, to render Specialty Drug services and certain administrative functions.

Non-Network Pharmacy Any appropriately licensed Pharmacy, located within the United States that is not a Participating Pharmacy under the terms and conditions of this Certificate. Also referred to as "Non-Participating Pharmacy".

Non-Network Providers Health care Providers that do not have a written agreement with Anthem BCBS to furnish health care services under this Contract. Also referred to as Non-Participating Providers. Providers who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this plan are also considered Non-Network Providers.

Orthognathic Surgery A branch of oral surgery dealing with the cause and surgical treatment of malposition of the bones of the jaw and occasionally other facial bones.

Orthotic Device A device that restricts, eliminates, or redirects motion of a weak or diseased body part.

Outpatient A patient who receives services at a Provider and who is not a registered Inpatient. A patient who is kept overnight in a Hospital solely for observation is considered an Outpatient. This is true even though the patient uses a bed.

Partial Hospitalization Program Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics (P&T) Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and

financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem's PBM in consultation with Anthem also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician See definition of "Provider."

Prescription Drug (Drug) (Also referred to as Legend Drug) A medicine that is approved by the Food & Drug Administration (FDA) ~~made~~ to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1) Compounded (combination) medications, when all ingredients are FDA-approved, as designated in the FDA's Orange Book: *Approved Drug Products With Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes

Prescription Order A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Prostheses Prostheses are appliances that replace all or part of a body organ (including contiguous tissue) or replace all or a part of the function of a permanently inoperative, absent, or malfunctioning body part.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Booklet. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- Acute-care Hospitals
- Skilled nursing facilities
- Rural Health Centers
- Home health agencies
- Ambulatory surgery centers
- Hospices
- Community Mental Health Centers
- Substance Abuse Treatment Facilities
- Licensed pharmacies
- Acute care psychiatric and rehabilitation Hospitals

- Independent laboratories
- Freestanding Imaging Centers
- Family planning agencies
- Durable Medical Equipment Providers
- Infusion Providers
- Other Providers that have written participating agreements with us;
- Other Providers, as required by law.

Physicians
- Doctor of Medicine
- Doctor of Osteopathy

Other Providers:
- Doctor of Optometry
- Doctor of Chiropractic
- Doctor of Podiatry
- Doctor of Dentistry
- Doctor of Psychology
- Licensed Audiologist
- Licensed Psychiatric Nurse Specialist
- Licensed Clinical Social Worker
- Licensed Clinical Professional Counselor
- Licensed Marriage and Family Therapist
- Licensed Pastoral Counselor
- Physical Therapist
- Occupational Therapist
- Speech Therapist
- Registered Nurse
- Licensed Practical Nurse
- Certified Nurse Midwife
- Ambulance Services
- Other Providers that have written participating agreements with us;
- Other Providers as required by law.

Radiation Therapy The use of high energy penetrating rays to treat an illness or disease.

Reconstructive Procedures Procedures performed on structures of the body to improve or restore bodily function or to correct deformity when there is functional impairment resulting from disease, trauma, previous therapeutic process, or congenital or developmental anomalies.

Retail Health Clinic A free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Rural Health Center An institution that meets both of the following requirements:
- Certified by the Department of Human Services under the United States Rural Health Clinic Services Act; and
- Meets our standards for participation.

Sitter/Companion A person who provides short-term supervision of Hospice patients during the temporary absence of family members.

Skilled Nursing Facility (SNF) An institution that meets all of the following requirements:

- Licensed as a Skilled Nursing Facility;
- Accredited in whole or in a specific part as a Skilled Nursing Facility for the treatment and care of Inpatients;
- Engaged mainly in providing skilled nursing care under the supervision of a Physician in addition to providing room and board;
- Provides 24-hour-per-day nursing care by or under the supervision of a registered nurse (RN);
- Maintains a daily medical record for each patient;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Specialist Service A service by a Provider practicing in specialty areas such as cardiology, neurology, surgery, and other specialties.

Specialty Drugs Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subcontractor An organization or entity that provides particular services in specialized areas of expertise. Examples of Subcontractors include, but are not limited to: Prescription Drugs, Mental Health/ behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

Subscriber The person who applied for coverage under this Contract and whose application and payment of required Subscription Charges we have accepted.

Subscription Charge The rates established by us as consideration for Benefits offered in this Contract.

Substance Abuse Treatment Facility A residential or nonresidential institution that meets all of the following requirements:

- Licensed or certified as a Substance Abuse Treatment Facility;
- Provides care to one or more patients for alcoholism and/or drug dependency;
- Is a freestanding unit or a designated unit of another licensed health care facility; and
- Meets our standards for participation.

Surgical Assistant A Physician (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified Provider as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered Surgical Service.

Surgical Service A service performed by a Provider acting within the scope of his or her license that is:

- A generally accepted operative and cutting procedure; or
- An endoscopic examination or other invasive procedure using specialized instruments; or
- The correction of fractures and dislocations.

Telemedicine The use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment. Telemedicine does not include the use of audio-only telephone, facsimile machine, or e-mail.

Terminal Illness A Terminal Illness exists if a person becomes ill with a prognosis of 12 months or less to live, as diagnosed by a Physician.

Tier Listing The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Treatment of Autism Spectrum Disorders The following types of care prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analsysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;

(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

Urgent Care / Walk-In Center A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Management The process we use to determine the medical necessity, appropriateness, efficacy or efficiency of health care services. Techniques include Inpatient admission review, continued Inpatient Stay review, discharge planning, post admission review, and case management.

Waiting Period The period required by your Group or us before enrollment in this Group health plan is allowed.

Section Seven
ERISA Rights

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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