Anthem BlueCross BlueShield

Underwritten by Community Insurance Company

Health Certificate of Coverage

(herein called the "Certificate")

Anthem Silver Pathway X PPO 3000/10%

RIGHT TO EXAMINE THIS CERTIFICATE: If this Certificate is provided to you as a new Subscriber, you have 10 days to examine this Certificate. If you are not satisfied with this Certificate, you may return it to Us or the agent who sold it to you within 10 days after you receive it, or have access to it electronically, whichever is earlier. Your Premium will be refunded and this Certificate will be void from its start.

Guaranteed Renewable: Coverage under this Certificate is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Certificate by payment of the renewal Premium by the Premium due date. The Exchange may refuse renewal only under certain conditions.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Anthem.

Community Insurance Company dba

Anthem Blue Cross and Blue Shield

1351 Wm. Howard Taft Road

Cincinnati, OH 45206

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC PROVIDERS AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Certificate has been prepared to help explain your coverage. Please refer to this Certificate whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services are provided by Us.

This Certificate should be read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated. The Certificate also contains **Noncovered Services/Exclusions**.

This Certificate supersedes and replaces any Certificate previously issued to you under the provisions of the Group Contract.

Read your Certificate carefully. The Certificate sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations, and Exclusions of your Certificate. **It is therefore important that you read your Certificate.**

How to Get Language Assistance

Anthem is committed to communicating with Our Members about their health plan, no matter what their language is. Anthem employs 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 Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

Anthem Blue Cross and Blue Shield

Member Rights and Responsibilities

As a Member, you have rights and responsibilities when receiving health care. As your health care partner, We want to make sure your rights are respected while providing your health benefits. That 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.

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 Certificate.
- 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.

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 an In-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 Member Services if you have any changes to your name, address or family members covered under your Certificate.

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 Member 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 overseen by your Certificate of Coverage, Member Handbook or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

Emergency care, urgent care, and ambulance services will be covered at the Network Cost-Share whether you get care from a Network Provider or Non-Network Provider. Emergency care, urgent care and ambulance services you get from a Non-Network Provider will be covered as a Network service, but you may have to pay the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. In addition, all other Covered Services received from Providers outside the State of Ohio (Non-Network Providers) will be covered at the Non-Network Cost-Share, and you may have to pay the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. In limited circumstances a Provider outside the State of Ohio may be a Network Provider, please refer to anthem.com for the most current list of Network Providers.

What will I pay?

This chart shows the most you pay for Deductibles and Out-of-Pocket expenses for Covered Services in one year of coverage.

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance, except for:

- Network Preventive Care Services required by law
- Pediatric Vision Services
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

In addition, We have designated certain Network hospitals as participating in Tier 1 or Tier 2. We have agreements in place with these hospitals to receive discounts on services; however, depending on the category, your Network Coinsurance may be different. Tier 1 hospitals have lower costs to Members than Tier 2 hospitals. If you go to a Non-Network hospital, there is no agreement on the cost of services, nor any designation as to Tier 1/Tier 2 hospitals. Therefore, you are responsible for a separate Non-Network Deductible and Out-of-Pocket Limit, in addition to, higher out-of-pocket Cost-Shares, and you may be billed for amounts above Our Maximum Allowed Amount.

Plan Features

Deductible	**Network Member Pays**	**Non-Network Member Pays**
Individual	$3,000	$9,000
Family	$6,000	$18,000
The individual Deductible applies to each covered family member. No one person can contribute more than their individual Deductible amount. Once two or more covered family members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that calendar year.		

Coinsurance	Network Member Pays	Non-Network Member Pays
Coinsurance Percentage (unless otherwise specified)	10% Coinsurance	40% Coinsurance

Out-of-Pocket Limit	Network Member Pays	Non-Network Member Pays
Individual	$6,000	$18,000
Family Includes Deductible, Copayments and Coinsurance	$12,000	$36,000
The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Limit.		

IMPORTANT: You are responsible for confirming that the Provider you are seeing or have been referred to see is a Network Provider for this Plan. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers that applies to this Plan.

Anthem can help you find a Network Provider specific to your Plan by calling the number on the back of your Identification Card.

Medical Services

Medical Services	Network Member Pays	Non-Network Member Pays
Ambulance Services		
Emergency	$0 Copayment 10% Coinsurance	$0 Copayment 10% Coinsurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if a Non-Network Provider is used.	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $3,000 per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Advanced Imaging Services	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Doctor Office Visits		
Primary Care Physician (PCP) Office Visits	First 3 visits: Deductible does not apply $40 Copayment; then 0% Coinsurance All subsequent visits: $0 Copayment; then 10% Coinsurance	$0 Copayment 40% Coinsurance
Specialty Care Physician (SCP) Office Visits	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Other Office Services	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Durable Medical Equipment (medical supplies and equipment)	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Emergency room visits (Copayment waived if admitted)	$200 Copayment 10% Coinsurance	$200 Copayment 10% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Habilitative Services – Autism Autism is covered for ages 0 – 21yrs as habilitative services with the following limits: Speech therapy: limited to 20 visits per Calendar Year Occupational therapy: limited to 20 visits per Calendar Year Mental/Behavioral Health Outpatient Services performed by a licensed psychologist, psychiatrist, or Physician **(The visit limits for Speech therapy and Occupational therapy for treatment of Autism are not combined with the limits listed under Therapy Services.)**	Copayment/Deductible/Coinsurance determined by service rendered. For services in the office, look to "Office Visits." For services in the outpatient department of a hospital, look to "Outpatient Facility Services".	
Home Health Care Limited to a maximum of 100 visits per Member, per Calendar Year Private Duty Nursing care provided in the home setting is limited to a maximum of 90 visits per Member, per Calendar Year	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Hospice Care	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Hospital Services		
Inpatient admission		
Tier 1 Hospital	$500 Copayment per admission 10% Coinsurance	$1,000 Copayment per admission 40% Coinsurance
Tier 2 Hospital	$500 Copayment per admission 40% Coinsurance	$1,000 Copayment per admission 40% Coinsurance
Outpatient	$0 Copayment per visit 10% Coinsurance	$0 Copayment per visit 40% Coinsurance
Inpatient and Outpatient Professional Services	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of 60 days per Member, per Calendar Year.	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Mental Health & Substance Abuse		
Inpatient admission		
Tier 1 Hospital	$500 Copayment per admission 10% Coinsurance	$1,000 Copayment per admission 40% Coinsurance
Tier 2 Hospital	$500 Copayment per admission 40% Coinsurance	$1,000 Copayment per admission 40% Coinsurance
Outpatient facility	$0 Copayment per visit 10% Coinsurance	$0 Copayment per visit 40% Coinsurance
Outpatient office visit	$0 Copayment per visit 10% Coinsurance	$0 Copayment per visit 40% Coinsurance
Preventive Care Services Network services required by law are not subject to Deductible.	$0 Copayment 0% Coinsurance	$0 Copayment 40% Coinsurance
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Skilled Nursing Care Limited to a maximum of 90 days per Member, per Calendar Year	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Surgery		
Inpatient admission		
Tier 1 Hospital	$500 Copayment per admission 10% Coinsurance	$1,000 Copayment per admission 40% Coinsurance
Tier 2 Hospital	$500 Copayment per admission 40% Coinsurance	$1,000 Copayment per admission 40% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Outpatient treatment	$0 Copayment per visit 10% Coinsurance	$0 Copayment per visit 40% Coinsurance
Ambulatory Surgical Center	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of 20 visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of 20 visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of 20 visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of 12 visits per Member, per Calendar Year **Cardiac Rehabilitation** Limited to a maximum of 36 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** **Limited to a maximum of 20** visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $10,000 maximum benefit limit per transplant Unrelated Donor Search - $30,000 maximum benefit limit per transplant	Benefits are based on the setting in which Covered Services are received.	
Urgent Care Center	$50 Copayment 10% Coinsurance	$50 Copayment 10% Coinsurance

Prescription Drugs

Retail Pharmacy Prescription Drugs (30-day supply per prescription)	**Network Member Pays**	**Non-Network Member Pays**
Tier 1	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Tier 2	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Tier 3	$0 Copayment 10% Coinsurance	$0 Copayment 40% Coinsurance
Tier 4 Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$0 Copayment 10% Coinsurance	Not Covered

Mail Order Prescription Drugs	**Network Member Pays**	**Non-Network Member Pays**
Tier 1 (90-day supply)	$0 Copayment 10% Coinsurance	Not Covered
Tier 2 (90-day supply)	$0 Copayment 10% Coinsurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 10% Coinsurance	Not Covered
Tier 4 (30-day supply) Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$0 Copayment 10% Coinsurance	Not Covered

Orally Administered Cancer Chemotherapy	Orally administered cancer Drugs. As required by Ohio law, you will not have to pay a Cost-Share (i.e., Copayment, Deductible or Coinsurance) for the Drugs you get at a Retail or Mail Order Pharmacy that is higher than the Cost-Share you pay for chemotherapy covered under the medical benefit.

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members up to the end of the month in which the Member turns age 19. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Certificate for a detailed description of services.

Pediatric Dental Care (for children up to the end of the month in which they turn age 19)	**Network** **Member Pays**	**Non-Network** **Member Pays**
Diagnostic and Preventive Services	10% Coinsurance	30% Coinsurance
Basic Restorative Services	40% Coinsurance	50% Coinsurance
Oral Surgery Services	50% Coinsurance	50% Coinsurance
Endodontic Services	50% Coinsurance	50% Coinsurance
Periodontal Services	50% Coinsurance	50% Coinsurance
Major Restorative Services	50% Coinsurance	50% Coinsurance
Prosthodontic Services	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	50% Coinsurance	50% Coinsurance

Pediatric Vision Services

The following benefits are available to Members up to the end of the month in which the Member turns age 19. To receive the Network benefit you must use a Blue View Vision Provider. For help finding a Blue View Vision Provider, please visit Our website or call Us at the number on your ID Card. Non-Network Providers may bill you for any charges that exceed Our Maximum Allowed Amount.

Covered vision services are not subject to the Deductible.

Pediatric Vision Care (for children up to the end of month in which they turn age 19)	**Network Copayment/Deductible**	**Non-Network Copayment/Deductible**
Routine Eye Exam	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Once per Calendar Year		
Standard Plastic Lenses*		
Once per Calendar Year		
Single Vision	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Bifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Trifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Progressive	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Lenses include the following lens options at no additional cost when received in Network: factory scratch coating, UV protective coating, standard polycarbonate lenses, standard photochromic or photosensitive lenses, blended segment lenses, intermediate vision lenses, progressive lenses, polarized lenses, anti-reflective coating, hi-index lenses, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.		
Frames*(formulary) This Plan offers a selection of covered frames.	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Once per Calendar Year		
Contact Lenses*(formulary)		

Pediatric Vision Care (for children up to the end of month in which they turn age 19)	**Network Copayment/Deductible**	**Non-Network Copayment/Deductible**
This Plan offers a selection of covered contact lenses.		
Once per Calendar Year		
Elective (conventional and disposable)	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Non-Elective	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Low Vision		
Comprehensive Low Vision Exam	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Once per Calendar Year		
Optical/Non-optical aids/Supplemental Testing	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year.		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Emergency care, urgent care, and ambulance services will be covered at the Network Cost-Share whether you get care from a Network Provider or Non-Network Provider. Emergency care, urgent care and ambulance services you get from a Non-Network Provider will be covered as a Network service, but you may have to pay the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. In addition, all other Covered Services received from Providers outside the State of Ohio (Non-Network Providers) will be covered at the Non-Network Cost-Share, and you may have to pay the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible. In limited circumstances a Provider outside the State of Ohio may be a Network Provider, please refer to anthem.com for the most current list of Network Providers.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Certificate. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider charge and 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 the Non-Network Provider's charge and the Maximum Allowed Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider 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. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We 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.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate. **Benefits for Covered Services are based on the Maximum Allowed Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Certificate.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- 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, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or Approved Facility.

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 during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by Anthem. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to Medical Necessity review by Anthem. Anthem retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Behavioral Health Services

Mental Health/Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include but are not limited to:

- **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 and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional clinical counselor (L.P.C.C.) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

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.

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 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.

The Plan may require you to use a 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 and that would otherwise be covered by this Certificate.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

The 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, itself; or
ii. Items and services that 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.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

We cover the following dental care services for Members up to the end of the month when the Member turns 19 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Certificate. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Certificate.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Certificate. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Certificate. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a

pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Certificate benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Certificate may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to Anthem, PO Box 1115, Minneapolis, MN 55440-1115.

Dental Providers

You do not have to select a particular dentist to receive dental benefits. You can choose any dentist you want for your dental care. However, your dentist choice can make a difference in what benefits are covered and how much you will pay out of pocket. You may have more out-of-pocket costs if you use a dentist that is a non-participating dentist. There may be differences in the amount We pay between a participating dentist and a non-participating dentist.

Please call our customer service department at the telephone number on the back of your ID Card for help in finding a participating dentist, or visit Our website at www.anthem.com/mydentalvision. Please refer to your ID card for the name of the dental program that participating providers have agreed to service when you are choosing a participating dentist.

Preventive Care

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

> NOTE: Comprehensive oral evaluations will be covered 1 time per dental office, subject to the 2 times per calendar year limitation. Any additional comprehensive oral evaluations performed by the same dental office will be covered as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.

Radiographs (X-rays)

- Bitewings - Covered at 1 series of bitewings per 6-month period.
- Full Mouth (Complete Series) - Covered 1 time per 60-month period.
- Panoramic – covered 1 time per 60-month period.
- Periapical(s)
- Occlusal
- Extraoral film.

Dental Cleaning (Prophylaxis) – Covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) - Covered 2 times per calendar year.

Fluoride Varnish - Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 time per 24-month period for permanent first and second molars.

Space Maintainers

Recement Space Maintainer

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Services

Consultations (other than dentist providing treatment)

Office Visits

Amalgam (silver) Restoration. Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Composite (white) Resin Restorations. Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

- Anterior (front) Teeth – Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth – Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the Certificate's Maximum Allowed Amount for the covered benefit and the dentist's submitted fee for the optional treatment, plus any Deductible and/or Coinsurance that applies.

Periodontal Maintenance – A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 4 times per 12-month period.

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Basic Non Surgical Periodontal Care – Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning – Covered 1 time per quadrant per 24 months.

Resin based composite resin crown, anterior – Covered 1 time per 24-month period.

Partial Pulpotomy for apexogenesis – Covered 1 time per lifetime on permanent teeth only.

Pin Retention

Pre-fabricated or stainless steel crown – Covered 1 time per 60-month period through age 14.

Therapeutic Drug Injection

Fabrication of Athletic Mouthguard

Internal Bleaching

Basic Endodontic Services (Nerve or Pulp Treatment)

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling

Periodontics (Gum & Bone Treatment)

Basic Non-Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Full mouth debridement – Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge – Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36-month period per single permanent tooth or multiple teeth in the same quadrant.

Crown Lengthening – Covered once per lifetime.

Chemotherapeutic Agents

Oral Surgery (Tooth, Tissue, or Bone Removal)

Basic Extractions

- **Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth**
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collect – apply autologous product – Covered 1 time per 36-month period.
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

General Anesthesia, Intravenous Conscious Sedation and IV Sedation – Covered when performed in conjunction with complex surgical service.

LIMITATION: General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

Major Restorative Services

Services performed to restore lost tooth structure as a result of decay or fracture.

Gold foil restorations – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the dentist's submitted fee for the optional treatment, plus any Coinsurance for the Covered Service.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION**:** If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the maximum allowed amount for the amalgam restoration and the inlay, plus any Deductible and/or Coinsurance that applies.

Onlays and/or Permanent Crowns - Covered 1 time per 5-year period per tooth, if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

LIMITATION: We will pay up to the maximum allowed amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance that applies.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair - Covered 1 time per 12-month period, per tooth, when the submitted narrative from the treating dentist supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown – Covered 1 per tooth every 60 months.

Occlusal Guards – Covered 1 per 12 months for Members age 13 through 18.

Prosthodontic Services (Dentures, Partials, and Bridges)

Tissue Conditioning

Reline and Rebase - Covered 1 time per 36-month period:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Clasps

Replacement of Broken Artificial Teeth - Covered 2 times per 24-month period:

- when the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments

Partial and Bridge Adjustments

Removable Prosthodontic Services (Dentures and Partials) - Covered 1 time per 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all Certificate limitations on the Covered Service.

Recement Fixed Prosthetic

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a pretreatment estimate be requested to estimate the amount of payment prior to beginning treatment.

Orthodontic Care – 12 Month Waiting Period

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover orthodontic care that is Dentally Necessary Orthodontic Care. You should submit your treatment Plan to Us before you start any orthodontic treatment to make sure it is covered under this Certificate.

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;

d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this Certificate) will be benefited on a pro-rated basis.

Orthodontic Exclusions

Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of your treatment. You must have continuous coverage under this Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your dentist indicating the estimated maximum allowed amount, including any amount (Coinsurance) you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by us, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to you and your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Please see the Non-Covered Services/Exclusions section of this Certificate for additional exclusions regarding Pediatric Dental Services.

Dental Appeals

Please submit appeals regarding your dental coverage to the following address:

Anthem Blue Cross and Blue Shield
PO Box 1122

Minneapolis, MN 55440-1122

Please see the Complaint and Appeals section for a detailed explanation of the appeal process.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Office Services, Emergency Care, and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction;
- anesthesia.

Other Dental Services

The Plan also includes coverage for dental services to prepare the mouth for medical services and treatments for:

- Transplant preparation.
- Initiation of immunosuppressives.
- Treatment related to an accidental injury as stated above.
- Cancer or cleft palate.

The only other dental expenses that are Covered Services are facility charges for Outpatient Services. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Certificate.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this section.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (Including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service; however, the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Coinsurance, Copayment or Deductible. In certain circumstances, Emergency Care received from a Non-Network Provider may be approved as an Authorized Service. You must contact Us for authorization prior to the claim being filed. In addition, if you contact your Physician and are referred to a Hospital Emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, seven (7) days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 24 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Certificate. If your Provider does not have a participation agreement with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network benefit unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance.

Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services received from a Non-Network Urgent Care Provider will be covered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Habilitative Services (includes Autism)

Benefits include health care services and devices that help you keep, learn or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Habilitative services also include benefits for children (ages 0 to 21) with a medical diagnosis of Autism Spectrum Disorder for:

- Outpatient Physical Habilitation services including:

    1. Speech therapy and/or Occupational therapy, performed by a licensed therapist, limited to the visits shown in the Schedule of Cost-Shares and Benefits; and
    2. Clinical Therapeutic Intervention defined as therapies supported by empirical (factual) evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the state of Ohio to perform the services in accordance with a treatment plan, limited to 20 hours per week;

- Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans, limited to the visits shown in the Schedule of Cost-Shares and Benefits.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy, which is not covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

- Private Duty Nursing.

Non-Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy - Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and/or administered in the home. Home IV therapy includes but is not limited to: injections (intra muscular; subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management, and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice services are those covered services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

Additional covered services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional covered services, which are described in other parts of this Certificate, are provided as set forth in other parts of this Certificate.

Inherited Metabolic Diseases

Covered Services include coverage for the necessary care and treatment of medically diagnosed inherited metabolic diseases.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for Room, Board and General Nursing Services;
- Ancillary (related) Services; and
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Facility Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules, consultations

requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.

- **Surgery and the administration of general anesthesia.**

- **Newborn examinations.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, abortion (only as noted below), and ordinary routine nursery care for a healthy newborn.

NOTE: Abortions in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

One Deductible and Copayment/Coinsurance will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

Note: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment/Coinsurance.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not 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 delivery by cesarean section. However, the issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Covered Services include at-home post delivery follow-up care visits at your residence by a Physician or Nurse. If you are discharged early (prior to the 48 or 96 hour prescribed stay) the follow up care must be performed no later than seventy-two (72) hours following you and your newborn child's discharge from the Hospital, to be considered a Covered Service. If you are discharged after the 48 or 96 hour prescribed stay, the follow up care must be deemed Medically Necessary to be a Covered Service. Coverage for the visit(s) includes, but is not limited to:

1) Parent education;

2) Physical assessments;

3) Assessment of the home support system;

4) Assistance and training in breast or bottle feeding; and

5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.

2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.

3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.

4) The equipment, supply or appliance is damaged and cannot be repaired.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the customer service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies -** Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts;

2. Chem strips, Glucometer, Lancets;

3. Clinitest;
4. Needles/syringes;
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non-Covered Services include but are not limited to:

1. Adhesive tape, bandages, cotton tipped applicators;
2. Arch supports;
3. Doughnut cushions;
4. Hot packs, ice bags;
5. Vitamins;
6. Medijectors
7. Elastic stockings or supports;
8. Gauze and dressings.

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Durable Medical Equipment** - The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Durable Medical Equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube

7. Cardiac, neonatal and sleep apnea monitors

8. Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include but are not limited to:

1. Air conditioners

2. Ice bags/coldpack pump

3. Raised toilet seats

4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment

5. Translift chairs

6. Treadmill exerciser

7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic Appliances -** Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

    1. Replace all or part of a missing body part and its adjoining tissues; or

    2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;

2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);

3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act; maximums for Prosthetic devices, if any, do not apply;

4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;

5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.

6. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered);

7. Cochlear implant;

8. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

9. Restoration prosthesis (composite facial prosthesis).

10. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth;

2. Dental appliances;

3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;

4. Artificial heart implants;

5. Wigs (except as described above following cancer treatment);

6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device 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 . The costs of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices include, but are not limited to, the following:

1. Cervical collars;

2. Ankle foot orthosis;
3. Corsets (back and special surgical);
4. Splints (extremity);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom-made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

Repair and replacement due to misuse, malicious breakage or gross neglect.

1. Replacement of lost or stolen items.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes;
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled "Behavioral Health Services" for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care, refer to the **"Emergency Care and Urgent Care**" section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled "Preventive Care Services", "Maternity Care", and "Home Care Services", for services covered by the Plan. For Emergency Care, refer to the "Emergency Care and Urgent Care" section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.

- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.

- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.

- **Therapy Services** for Physical Medicine Therapies and Other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. 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.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

> **Note:** Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy benefits manager from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy benefits manager.

Prescription Drug List

We also have a 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.

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.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please contact the customer service telephone number on the back of your Identification Card.

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

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain drugs if they are not on the Prescription Drug list. Generally, it includes select Generic Drugs with limited Brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com.

Exception Request for a Drug not on the Prescription Drug List

If you or your Doctor believe 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 within 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 an external review by an IRO. The IRO will make a coverage decision 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.

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.

Benefits are available for the following:

- Prescription 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; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration);
- **Orally administered cancer Drugs:**
  a) (If your Plan has a Deductible and Copayments on all Benefits). As required by Ohio law, you will not have to pay a Cost-Share (i.e., Copayment, Deductible or Coinsurance) for the Drugs you get at a Retail or Mail Order Pharmacy that is higher than the Cost-Share you pay for chemotherapy covered under the medical benefit; **or**
  b) (If your Plan has Prescription Drug Copayments or Coinsurance). As required by Ohio law, your Cost-Share (i.e., Copayment, Deductible or Coinsurance) will not be more than $100 per Prescription Order;
- Drugs for off label use only when approved by Us or the PBM, or when the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets certain criteria. Medical literature may be accepted only if all of the following apply: (1) Two articles from major peer-reviewed professional medical journals have recognized the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; (2) No article from a major peer-reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; (3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer-reviewed medical literature.

Where You Can Obtain Prescription Drugs

Your Benefit Program 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 Mail Service 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.

Retail

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. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy may charge you the full retail price of the Prescription and may 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.

If We determine that you may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, your selection of Participating Pharmacies may be limited. If this happens, We may require you to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify you, We will select a single Participating Pharmacy for you.

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

Maintenance Medication - Home Delivery Complete

The PBM also has a Mail Service Pharmacy that you will use to obtain Drugs you take on a regular basis. If you are taking a Maintenance Medication, you may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at your local Retail Pharmacy. You must then use the Mail Service Pharmacy.

You will need to contact the PBM to sign up when you first use the service. The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Mail Service Pharmacy. The Prescription must state the dosage and your name and address; it must be signed by your Physician. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible, if any, that applies when you obtain Prescription Drugs.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service at the number on the back of your Identification Card.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at the telephone number on the back of your Identification Card for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is 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.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your specialty Drug from the Specialty Preferred Program by calling customer service at the telephone number on the back of your Identification Card. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization.

When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services at the telephone number on the back of your Identification Card or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a participating pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Benefit Program 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 Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior Authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Complaint and Appeals Procedures” section of this Certificate.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Benefit Program. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand or Generic Drugs are covered under the Benefit Program.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Benefit Program also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

> **Helpful tip**: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

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.

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 a retail 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 Member Services number on your Member ID Card or log on to the Member website at www.anthem.com.

Special Programs

Except where 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. In addition, We may allow access to network rates for drugs not listed on Our formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
1351 Wm. Howard Taft Road
Cincinnati, OH 45206

Monday through Friday - 8:00 a.m. to 5:00 p.m.

You may visit Our home office during normal business hours.

Please see the Non-Covered Services/Exclusions section of this Certificate for additional exclusions regarding Prescription Drugs services.

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Certificate with no Deductible, Copayments or Coinsurance from the Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an “A” or “B” rating from the United States Preventive Services Task Force:

   Examples of these services for screenings are:

   Breast cancer;
   Cervical cancer;
   Colorectal cancer;
   High Blood pressure;
   Type 2 Diabetes Mellitus;
   Cholesterol;
   Child and Adult obesity

2) Immunizations 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) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   a) Women’s contraceptives, sterilization procedures, and counseling. This includes Generic drugs only, unless there is no Generic equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic equivalents are available, Prescription Brand Name contraceptives will not be covered unless Medically Necessary, under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the “Prescription Drugs” section.

   b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be covered as Non-Network. Benefits for breast pumps are limited to one per calendar year or as required by law.

   c) Gestational diabetes screening.

For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html.

You may call Customer Service using the number on your ID card, or review Our website at www.anthem.com for additional information about covered Preventive Services.

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Cochlear implants
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Certificate.

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Certificate.

Sterilization

Sterilization is a Covered Service. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

They are covered if provided within Our guidelines.

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapies

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a Social Worker or Psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;

2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Certificate.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your

benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call Us to find out which Hospitals are In-Network Transplant Providers. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and

- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, collection and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member Cost-Shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Cost-Shares and Benefits.

Vision Care Services for Pediatric Members

The following vision care benefits are available to Members up to the end of the month in which the Member turns age 19.

We will cover vision care that is listed in this section. See your Schedule of Cost-Shares and Benefits for the benefit frequencies and your Cost-Share amounts for covered vision care. To receive the Network benefit you must use a Blue View Vision Provider. For help finding a Blue View Vision Provider, please visit Our website, or call Us at the number on your ID Card. We will not pay for vision care listed in the "Non-Covered Services/Exclusions" section of this Certificate.

Routine Eye Exam

Your Certificate covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision.

Eyeglass Lenses

You have a choice in your eyeglass lenses. Lenses include the following lens options at no additional cost when received in Network: factory scratch coating, UV protective coating, standard polycarbonate lenses, standard photochromic or photosensitive lenses, blended segment lenses, intermediate vision lenses, progressive lenses, polarized lenses, anti-reflective coating, hi-index lenses, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.

Covered standard eyeglass lenses include:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive
- lenticular

Frames

There is a formulary of frames available to you. See your Provider for more information.

Elective Contact Lenses*

Elective contact lenses are contacts that you choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.

Non-Elective Contact Lenses*

Non-elective contacts are appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Non-elective contact lenses are only provided for the following conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses, pathological myopia, aphakia, anisometropia, aniseikonia, anirdia, corneal disorders, post-traumatic disorders, irregular astigmatism.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in the Schedule of Cost-Shares and Benefits. There is a formulary of contact lenses available to you. See your Provider for more information.

Low Vision
Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices, and provide training instruction to maximize the Member's vision.

Pediatric Vision Coverage Appeals

Please submit appeals regarding your vision coverage to the following address:

Blue View Vision
555 Middle Creek Parkway
Colorado Springs, CO 80921

Vision Services (All Members / All Ages)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information. The Copayment/Deductible/Coinsurance will be determined by service rendered. For services in the office, look to "Office Visits." For services in the outpatient department of a hospital, look to "Outpatient Facility Services".

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the" "Prosthetics" benefit.

Additional Covered Services include:

- Determination of refraction,
- Routine Ophthalmological examination including refraction for new and established patients, and
- A visual functional screening for visual acuity.

These additional services are not part of the "Preventive Care" benefit and will be based on the setting in which services are received. No additional ophthalmological services are covered, except as described above.

Please see the Non-Covered Services/Exclusions section of this Certificate for additional exclusions regarding Pediatric Vision Services.

NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

We do not provide benefits for procedures, equipment, services, supplies or charges:

Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group

For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

Charges incurred after the termination date of this coverage.

Incurred prior to your Effective Date.

Complications directly related to a service or treatment that is a non Covered Service under this Certificate because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Certificate. Directly related

means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

For marital counseling.

For court ordered testing or care, unless the service is Medically Necessary.

We do not pay services, supplies, etc. for the following:

- Custodial Care, convalescent care or rest cures.
- 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.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

For Dental braces unless specifically stated as a Covered Service.

For Dental implants unless specifically stated as a Covered Service.

For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Certificate. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppressives.
- Treatment related to an accidental injury,
- cancer, or cleft palate.

For services or supplies primarily for educational, vocational, or training purposes, such as structured teaching, applied behavior analysis, etc. except as otherwise specified herein.

For abortions for which Federal funding is not allowed in accordance with Affordable Care Act section 1303(b)(1)(B)(i), namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed.

For examinations relating to research screenings.

Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be experimental/Investigative.

For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

- cleaning and soaking the feet.
- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

For completion of claim forms or charges for medical records or reports unless otherwise required by law.

To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

For surgical treatment of gynecomastia.

For hearing aids or examinations for prescribing or fitting them, except as specified in the “Covered Services” section of this Certificate.

Human Growth Hormones for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.

For treatment of hyperhydrosis (excessive sweating).

For Diagnostic testing or treatment related to infertility.

For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

In excess of Our Maximum Allowable Amounts.

Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled.

For missed or canceled appointments.

For which you have no legal obligation to pay in the absence of this or like coverage.

For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

For care received in an Emergency Room that is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to, suture removal in an Emergency Room.

For nutritional and dietary supplements. 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 the written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to Covered Services received for Home Infusion Therapy under the "Home Care Services" benefit.

For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Certificate or as required by law.

For personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, unless the benefit has not been exhausted, and the benefit is not payable by any other source.

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.

For stand-by charges of a Physician.

For Physician charges:

- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

  Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Certificate. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

For private duty nursing services, unless home nursing services provided through home health care. Private duty nursing services in an Inpatient setting are not covered.

Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.

Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

For reversal of sterilization.

For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, nuclear accident or engaging in an illegal occupation.

Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

For self-help training and other forms of non-medical self care, except as otherwise provided herein.

Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

For treatment of telangiectatic dermal veins (spider veins) by any method.

For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Certificate or as required by law.

For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

For vision orthoptic training.

For any service for which you are responsible under the terms of this Certificate to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION:

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 We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or

- 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; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, 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.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- 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
- 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.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- 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
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or 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
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

The following prescription drug services are not covered:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by us or the Pharmacy Benefits Manager PBM.

- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
- Compound 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.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- 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 "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- 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, unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Drug is more medically beneficial than the clinically equivalent alternative.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by us.
- 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.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Over the counter Drugs, devices or products, are not Covered Services.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless we must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription 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. This includes Prescription Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes, except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Prescription Drugs used to treat infertility.

Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Certificate.
- Services and materials that are Experimental or Investigational.

- Services or materials which are rendered prior to your Effective Date or after this coverage ends.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by licensed personnel.
- Services and materials resulting from your failure to comply with professionally prescribed treatment.
- Telephone consultations.
- Prosthetic devices and services.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the member's immediate family, including the member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Certificate.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Certificate.
- Any services that are strictly cosmetic in nature, including but not limited to charges for personalization or characterization of eyewear.
- Special lens designs or coatings, other than what is specifically stated as covered in this Certificate.

Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.

- Dental services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a member receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this policy will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving medical assistance.

- Dental services or health care services not specifically covered under the *policy* (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).

- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.

- Dental services completed prior to the date the Member became eligible for coverage.

- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.

- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.

- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Interim dentures.
- Enamel microabrasion and odontoplasty.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Adjunctive pre-diagnostic tests.
- Cone beam images.
- Anatomical crown exposure.
- Surgical placement: Temporary anchorage devices.
- Sinus augmentation.
- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances.
- Separate services billed when they are an inherent component of another Covered Service.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.

ELIGIBILITY AND ENROLLMENT

Coverage provided under this Certificate is made available to you because of your membership with the Group.

Eligibility

The benefits, terms and conditions of this Certificate are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Certificate, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2. Be qualified by the Exchange as eligible and under the age of 30, unless otherwise specified, if applying to purchase a Catastrophic Plan.
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of Ohio; and meet the following applicable residency standards;

   For a Qualified Individual age 21 and over, the applicant must:

   - Not be living in an institution
   - Be capable of indicating intent
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area of the Exchange

   For a Qualified Individual under age 21, the applicant must:

   - Not be living in an institution
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
   - Not be emancipated
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area of the Exchange
6. Agree to pay for the cost of Premium that Anthem requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address); or
2. has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.

2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a. For purposes of this Certificate, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b. A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c. To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children to the end of the month in which they turn age 26;
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian, to the end of the month in which they turn age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Certificate.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Certificate unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Certificate. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Certificate must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Certificate, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Certificate, and once approved by the Exchange We will provide the benefits of this Certificate in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Certificate will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the month following the event, as long as the application is received within 30 days of the event.

Effective dates for Loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage for any of the following:
    - An individual no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, or
    - Exhaustion of COBRA benefits.

Effective dates of Loss of Minimum Essential Coverage does not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and Certificate for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to the Exchange.
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3. The Member fails to pay his or her Premium.
4. Rescission of the Member's coverage.
5. The QHP terminates or is decertified.
6. The Member changes to another QHP; or
7. The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
   a. The termination date specified by the Member, if reasonable notice is provided;
   b. Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
   c. On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4. In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Certificate is guaranteed renewable at the option of the Group Contract holder and provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Certificate by payment of the renewal Premium by the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Certificate;
3. This Certificate has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Certificate, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Certificate as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Certificate

This Certificate may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Certificate. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Certificate if we decide to discontinue a health coverage product that We offer in the individual market. If we discontinue a health coverage product, we will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Grace Period for Subscribers Receiving APTC

The grace period is an additional period of time during which coverage remains in effect and refers to the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC). If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered.

If the Subscriber receiving the APTC has previously paid at least one month's premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to terminate the Certificate as provided herein.

If the Subscriber receiving the APTC does not pay the required premium by the end of the grace period, the Certificate is terminated. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

After Termination

Once this Certificate is terminated, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services received after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Network Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Complaints and Appeals" section of this Certificate.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

For services rendered by Network Providers:

- You will not be required to file any claims for services you obtain directly from Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Certificate.

- Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Cost-Shares and Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

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.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

- See the Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's Network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Certificate. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Certificate has the right to services or benefits under this Certificate. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

Maximum Allowed (Allowable) Amount (MAA)

General

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Certificate for additional information.

The Maximum Allowed Amount for this Plan 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 Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Plan.

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-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. 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. It only 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.

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.

PROVIDER NETWORK STATUS

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

A Participating Provider is a Provider who is in the managed network for this specific Plan or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with

Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send 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 Participating Provider or visit our website at www.anthem.com.

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

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, 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 for 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 reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; 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.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

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

Unlike Participating Providers, Non-Participating 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. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem 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 yourr 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.

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 Certificate, your may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include:

- amounts over the Maximum Allowed Amount;
- amounts over any policy maximum or limitation;
- expenses for services not covered under this Certificate; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

The individual Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Limit.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Cost-Sharing will be required for the remainder of the calendar year, except for Out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any Out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Network/participating 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 Cost-Shares and Benefits in this Certificate for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan'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 may be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Network/participating or Non-Network/nonparticipating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Certificate, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your 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/Participating 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.

Authorized Services

In some non-Emergency circumstances, We may Prior-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/Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network/Non-Participating Provider you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. You will only be liable for the Network Cost-Share amount if Our authorization was due to a Network Provider not being available for the Covered Services you required. Please contact Customer Service for Prior Authorized services information or to request authorization.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Certificate. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as described in this Certificate.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, for your information, you will receive a copy of that request for additional information. In those cases, We cannot complete the processing of the claim until the additional

information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Note: Under Ohio law, you have the right to obtain an itemized copy of your billed charges from the Hospital or Facility which provided services.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

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 3 years after expiration of the time within which notice of claim is required by the Certificate. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When you obtain Covered Services outside of Anthem's service area, the claims may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below. They may also include negotiated national account arrangements between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when you access medical care outside Anthem's service area, you will obtain it from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non-participating Providers. Anthem's payment practices in both cases are generally described below.

BlueCard® Program

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

When you obtain Covered Services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

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 a special arrangement with that Provider or Provider group. 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 and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the types of transactions noted above. But, such adjustments will not affect the price on the claim that Anthem will use to determine the amount you pay.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state law mandates other liability calculation methods, including a surcharge, Anthem calculates a member's liability for any covered service according to applicable law.

Non-Participating Healthcare Providers Outside Anthem'sService Area

Member Liability Calculation

When you obtain Covered Services from non-participating healthcare Providers outside of Anthem's Service Area, the amount you pay for the services and supplies will generally be based on either: (a) the Host Blue's non-participating Provider local payment; or (b) the pricing arrangements required by applicable state law. In these cases, you may be responsible for the difference between: (a) the amount that the non-participating Provider bills; and (b) the payment Anthem makes for the Covered Services.

In some cases, Anthem may pay such claims differently than described above. For example, Anthem's payment for Covered Services obtained from non-participating Providers could be made based on: (a) billed Covered Charges; (b) the payment Anthem would make if the Covered Services had been obtained within its Service Area; or (c) a special negotiated payment, as allowed under Inter-Plan Program rules. In these cases, you may be liable for the difference between: (a) the amount that the non-participating healthcare Provider bills; and (b) the payment Anthem makes for the Covered Services.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide 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 BlueCard WorldWide 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. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

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 "Requesting Approval for Benefits" paragraphs further in this Certificate. 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 BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, 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 need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by the Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost-effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, 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. For labor / 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.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Certificate to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Certificate or is Experimental/Investigative as that term is defined in this Certificate.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other 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 will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, 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.

Who is responsible for Precertification	
Services given by a Network Provider	**Services given by a BlueCard/Non-Network/Non-Participating Provider**

Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part if the service is found to not be Medically Necessary after a Retrospective review. • For Emergency admissions, 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.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. These 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. We will administer benefits for any medically necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigational as that term is defined in the Plan otherwise. Your Certificate takes precedence over these guidelines.

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.

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

In addition, We may select certain qualifying Providers to participate in a program 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 Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification 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 Plan's Members.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

If an urgent care review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an appeal through Our internal appeal process.

- **Prospective** - A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

  If a continued stay review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an appeal through Our internal appeal process.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

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 Certificate was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Urgent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Urgent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	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 give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. 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 benefit 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.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. 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 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.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Certificate. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance and Copayment amounts,
- Specific claims or services you have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the Plan. The Plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in Our Networks.

The Complaint Procedure

We want your experience with Us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Customer Service by calling the number on the back of your ID Card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from Us of Our procedures and your Certificate. You may submit your complaint by letter or by telephone call. If your complaint involves issues of Covered Services, you may be asked to sign a release of information form so We can request records for Our review.

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. We will explain why benefits were denied and describe your rights under the Appeal Procedure. If you are not satisfied with the resolution of your complaint, you have the right to file an Appeal which is defined as follows:

Appeal Procedures

As a Member of this Plan you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why We denied your claim or request for benefits will describe the steps you should follow to initiate your appeal and how the appeal process works.

An appeal is a request from you for Us to change a previous determination or to address a concern you have regarding confidentiality or privacy.

Please refer to the section “Prescription Drug List” for the process for submitting an exception request for Drugs not on the Prescription Drug List.

Internal Appeals

An initial determination by Us can be appealed for internal review known as an appeal. The Plan will advise you of your rights to appeal further if a denial occurs after determination of an appeal.

You have the right to designate a representative (e.g. your Physician) to file appeals with Us on your behalf and to represent you throughout the appeals process. If a representative is seeking an appeal on your behalf, We must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until We have received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

We will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

To obtain information on Our appeal procedures or to file an oral appeal please call the toll free customer service number listed on the back of your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from Us.

We will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 105568, Atlanta, GA 30348-5568, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from Us.

Upon Our receipt of your written or oral appeal at the appeals address or telephone number provided above or provided on any notice of an adverse decision, We will send you an acknowledgment within 5 business days notifying you that you will receive a written response to the appeal once an investigation into the matter is complete. Our acknowledgment may be oral for those appeals We receive orally.

Appeals

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, We will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your Certificate. If the clinical peer determines that the service is covered by your Certificate We must pay for the service; if the clinical peer determines that the service is not covered We may deny the services.

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date We receive your appeal request. If more information is needed to make a decision on your Appeal, We will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, We will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, We will provide you with a written response indicating Our decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on your Appeal, We shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, We shall conduct its review based upon the available information.

Expedited Reviews

Expedited Review of an appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after Our receipt of the request and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending Physician or ordering Provider, and the facility rendering the service.

You may request an expedited review for:

1) Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
   Could seriously jeopardize your life or health or your ability to regain maximum function, or,
2) In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- We agree to waive the exhaustion requirement; or
- You did not receive a written decision of Our internal appeal within the required time frame; or
- We failed to meet all requirements of the internal appeal process unless the failure:
  1) Was de minimis (minor)
  2) Does not cause or is not likely to cause prejudice or harm to you;
  3) Was for good cause and beyond Our control:
  4) Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

External Review

Definitions as used in the External Review section include the following:

"Adverse benefit determination" means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
- A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
- A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non employer group, to participate in a plan or health insurance coverage;
- A determination that a health care service is not a covered benefit;
- The imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

"Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

"Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

"Covered benefits" or **"benefits"** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

"Emergency medical condition" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

"**Emergency services**" means the following:

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition;
- Such further medical examination and treatment that are required by federal law to stabilize an emergency medical condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

"Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health plan issuer" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

"Independent review organization" means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

"Rescission" or **"to rescind"** means a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a termination or discontinuance of coverage that has only a prospective effect or a termination or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

"Stabilize" means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    a) Serious impairment to bodily functions;
    b) Serious dysfunction of any bodily organ or part.

- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

"Superintendent" means the superintendent of insurance.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by Us to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the

following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least one of the following:
    a) Standard health care services have not been effective in improving the condition of the covered person.
    b) Standard health care services are not medically appropriate for the covered person.
    c) No available standard health care service covered by Us is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain

maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external

review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND Our decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through Us within 180 days of the date of the notice of final adverse benefit determination issued by Us. . All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to Us no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete We will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. We will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete We will inform the covered person in writing and specify what information is needed to make the request complete. If We determine that the adverse benefit determination is not eligible for external review, We must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Us and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When We initiate an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Us, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by Us in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Us of a request for a standard review or within 72 hours of receipt by Us of a request for an expedited review. This notice will be sent to the covered person, Us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on Us except to the extent We have other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Us.

If You Have Questions About Your Rights or Need Assistance

You may contact Us:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348-5568
To contact us by phone, please call the number on back of your identification card
Fax: 1-888-859-3046
For online appeal requests, please contact us at: www.anthem.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215

800-686-1526 / 614-644-2673

614-644-3744 (fax)

614-644-3745 (TDD)

Contact ODI Consumer Affairs:

https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:

http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

Appeal Filing Time Limit

We expect that you will use good faith to file an appeal on a timely basis. However, We will not review an appeal if it is received after 180 days have passed since the incident leading to your appeal, unless there are extenuating circumstances.

Appeals by Members of ERISA Plans

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file an appeal prior to bringing a civil action under 29 U.S.C. 1132§502(a).

GENERAL PROVISIONS

Entire Contract

Note: the laws of the state in which the Group Contract was issued will apply unless otherwise stated herein.

This Certificate, the Group Contract, the application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

Change to Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

This Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order of benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**.

The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

Definitions

A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1) **Plan** includes: group and non group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2) **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

This plan means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

The order of benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health care coverage under more than one **Plan**. When **This plan** is primary, it determines payment for its benefits first before those of any other **Plan** without considering any other **Plan's** benefits. When **This plan** is secondary, it determines its benefits after those of another **Plan** and may reduce the benefits it pays so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

The following are examples of expenses that are not **Allowable expenses**:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses.
2. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
3. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
4. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's**

payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

5. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
6. 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.
7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

Closed panel plan is a **Plan** that provides health care benefits to covered persons primarily in the form of services through a panel of providers which have contracted with or are employed by the **Plan**, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more **Plans**, the rules for determining the order of benefit payments are as follows:

A. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other **Plan**.
B. (1) Except as provided in Paragraph (2), a **Plan** that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both **Plans** state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.
C. A **Plan** may consider the benefits paid or provided by another **Plan** in calculating payment of its benefits only when it is secondary to that other **Plan**.
D. Each **Plan** determines its order of benefits using the first of the following rules that apply:
    - Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent, and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, policyholder, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.
    - Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order of benefits is determined as follows:
        - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
            - The **Plan** of the parent whose birthday falls earlier in the calendar year is the **Primary plan**; or
            - If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

- For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

- For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- Active employee or retired or laid-off employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.
- Longer or shorter length of coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.
- If the preceding rules do not determine the order of benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, This plan will not pay more than it would have paid had it been the **Primary plan**.

Effect On The Benefits Of This Plan

When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Us any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another **Plan** may include an amount that should have been paid under **This plan**. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under **This plan**. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than it should have paid under this **COB** provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Follow the steps described in the "Complaint and Appeals Procedures" section of the Certificate. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at http://insurance.ohio.gov.

Medicare

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Certificate for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed

by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purpose of the calculation of benefits, if the Member has not enrolled in the Medicare Parts B and/or D, We will calculate benefits as if they had enrolled.

Worker's Compensation

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Subrogation and Right of Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine

does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  1) The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
  2) You fail to cooperate.

In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.

- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly 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.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the Recovery method makes providing such notice administratively burdensome.

Misstatement of Age

If a Member's age has been misstated, We will adjust the Premiums and/or benefits under this Certificate. The benefits will be the amount the Premiums paid would have purchased at the correct age.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a Premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior Premium notice.

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of Premium is also printed on your Premium notice; however, this amount is subject to change. We have the right to increase a Member's Premium at any time in the future. We will not increase Premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new Premium amount.

If a Premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Certificate will be terminated at the end of the period for which full Premiums have been paid and you will receive a refund of any unearned Premium.

If a decrease in Premium is appropriate, We will adjust what is owed to Us and let you know the new amount of Premium due. We will refund or credit the overage amount.

If We have not charged the proper amount of Premium, We will let you know the new amount of Premium due from you. We will refund or credit the overage amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If Premium has been paid for any period of time after the date you terminate this Certificate, We will refund that Premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Certificate is in force, We will refund the Premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

The rates are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Certificate may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Premium Refund

Premium refunds shall not be retroactive, unless such request is made within the first ten (10) days after you receive the Certificate.

Interpretation of Certificate

The laws of the State which issued the Certificate of Authority to the Plan, shall be applied to the interpretations of this Certificate. Where applicable, the interpretation of this Certificate shall be guided by the pre-paid nature of the Plan’s operations as opposed to a fee-for-service indemnity basis.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirement of such laws.

Modifications

This Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Trust without the consent or concurrence of any Member. Any amendments are subject to approval by the Department of Insurance prior to use. By electing medical and hospital coverage under the Plan or accepting the Plan

benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 20 U.S.C. 1001 et seq.

The Plan, 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 set forth herein. However, We, or anyone acting on Our behalf, has 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 Allowable Amount. However, a Member may utilize all applicable Complaint and Appeals procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Certificate, to determine all questions arising under the Certificate and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract, the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Headings

The headings and captions in this Certificate are not to be considered a part of this Certificate and are inserted only for purposes of convenience.

Severability

In the event that any provision is this Certificate is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Certificate will remain in force and effect.

Community Insurance Company Note

The Subscriber hereby expressly acknowledges its understanding that this Certificate is part of a contract solely between the Group and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of

Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and/or Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Subscriber further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Community Insurance Company (Anthem), and that no person, entity, or organization other than Community Insurance Company (Anthem) shall be held accountable or liable to the Subscriber for any of Community Insurance Company (Anthem's) obligations to the Subscriber created under this Certificate. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

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 Certificate. 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 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.)

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.

Relationship of Parties (Anthem and Network Providers)

The relationship between Anthem and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of Ours, nor is Anthem, or any employee of Anthem, an employee or agent of Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any Network Provider or for any injuries suffered by you while receiving care from any Network Provider's Facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including

Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Us.

Payment Innovation Programs

We pay 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 a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, 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 Health Care Services provided to you, but instead, are based on the 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 Network Providers to Us under the Program(s).

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMSCO) as having a right to enrollment under the Group Certificate with regard to such Subscriber.

Alternative Care Facility – a non-Hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
2. Surgery;
3. Therapy Services or rehabilitation.

American Indian - The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period - The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum - The maximum We will pay for specific Covered Services during a Benefit Period.

Benefit Year - The term Benefit Year means a calendar year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Certificate – This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and it is subject to the terms of the Group Contract.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays

the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract - The agreement between the Trustee and Us, referred to as the Contract or Group Contract, as may be amended from time to time.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto;
- Authorized in advance by Us if such Prior Authorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and the other cost share amount) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

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 regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Day Hospital – A facility that provides day rehabilitation services on an Outpatient basis.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services that are subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dentally Necessary Orthodontic Care – A service for pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the Dental Services – Dental Care for Pediatric Members section for more information.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Certificate as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

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.

Effective Date - The date when your coverage begins under this Certificate. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the eligibility requirements in the Group Contract and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the 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 bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an emergency medical condition:

1. A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2. Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an emergency medical condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Essential Health Benefits - Defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or

- reliable evidence shows it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying the substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

Family Coverage - Coverage for the Subscriber and eligible Dependents**.**

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com

Generic Drugs – The term Prescription Drugs means that the 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.

Group – means the Trustee to whom the Group Contract is issued, and all Eligible Persons.

Group Contract (or Contract) – the agreement between the Trustee and Us, referred to as the Contract or Group Contract, as may be amended from time to time.

Habilitative/Habilitation Services - Health care services and devices that help you keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Home Health Care Agency - A facility which:

1. Provides skilled nursing and other services on a visiting basis in the Subscriber’s home; and

2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

Hospice (Care) - A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Hospital - An institution which maintains an establishment for the medical or surgical care of bed patients for a continuous period longer than twenty-four hours and which:

1. Is open to the general public twenty-four hours each day for Emergency care; and
2. Has a minimum of ten patient beds; and
3. Has an average of two thousand patient days per annum; and
4. Has on duty a Registered Nurse twenty-four hours each day; and
5. Is not primarily providing psychiatric, rehabilitative, drug or alcoholism treatment.

Identification Card - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

In-Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Certificate. A Hospital may be an In-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – A Prescription Drug program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator and/or the Plan, and sent directly to the Member's home.

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 Customer Service at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Maximum Allowed Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medically Necessary services must be cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative

service or sequence of services that is medically appropriate, or (2) performed in the least costly setting that is medically appropriate.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called “you” and “your”.

Mental Health and Substance Abuse - is 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.

Minimum Essential Coverage - The term means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions for the network associated with this Certificate.

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Out-of-Network Transplant Facility - Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be an Out-of-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Cost-Sharing is required unless otherwise specified in this Certificate.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means 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 - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem National Pharmacy and Therapeutics 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.

Plan (We, Us, Our) – Community Insurance Company which provides or arranges for Members to receive the Covered Services which are described in this Certificate.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges that must be paid by the Subscriber to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is 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, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

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

Primary Care Physician (PCP) – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Certificate. If you have a question about a Provider not described in this Certificate please call the number on the back of your Identification Card.

Qualified Health Plan or QHP: The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer - The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual - The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Certificate.

Self-Administered Drugs - The term Self-Administered Drugs means drugs that are administered which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage - Coverage for the Subscriber only.

Skilled Nursing Facility - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or Custodial Provider or similar place.

Specialty Care Physician (SCP) – A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an Emergency department or other care setting where Emergency Care is provided to you;
- Your transfer from an Emergency department or other care setting to another facility; or
- Your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State - The term State means each of the 50 States and the District of Columbia.

Subcontractor – Anthem 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 and Mental Health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer services duties on "Our behalf."

Subscriber – A member of the Group who is eligible to receive benefits under the Group Contract.

Tax Dependent - The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer - The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

1. To file an income tax return for the Benefit Year
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the Covered Services section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs.

Tier 1 Hospital - Hospitals that have lower costs to the Member. This Tier ranking is based solely on cost of services. While these hospitals are contracted with Us, we make no representation on the relative quality of the services. When a Member goes to a Non-Network hospital, there is no agreement on the cost of the service and the Member is responsible for the difference between the Non-Network hospital's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

Tier 2 Hospital - Hospitals that have higher costs to the Member. This Tier ranking is based solely on cost of services (unless no hospitals in the county met the financial criteria used to designate Tier 1). While these hospitals are contracted with Us, we make no representation on the relative quality of the services. When a Member goes to a Non-Network hospital, there is no agreement on the cost of the service and the Member is responsible for the difference between the Non-Network hospital's charge and the Maximum Allowed Amount, as well as any applicable Coinsurance, Copayment or Deductible.

Trust Agreement – The agreement between the Trustee and Us which establishes our Individual Insurance Trust.

Trustee – The person with whom We have contracted to oversee the Trust Agreement, and to whom the Group Contract is issued. The Trustee is the policyholder.

Urgent Care Center – A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.