Anthem Silver Pathway X Enhanced HMO 4000/0%

POLICY

What You need to know about Your Individual health Policy.

IMPORTANT NOTICE

THIS POLICY REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO YOUR HEALTH INSURANCE POLICY.

IF THIS POLICY IS PROVIDED TO YOU AS A NEW SUBSCRIBER, YOU MAY, AT ANY TIME WITHIN THIRTY (30) DAYS AFTER ITS RECEIPT, RETURN IT TO US BY DELIVERING IT OR MAILING IT TO ANTHEM BLUE CROSS AND BLUE SHIELD. IMMEDIATELY UPON SUCH DELIVERY OR MAILING, THE POLICY WILL BE DEEMED VOID FROM THE BEGINNING, AND ANY PREMIUM PAID WILL BE REFUNDED LESS ANY CLAIMS PAID.

THE BENEFITS DESCRIBED IN THIS POLICY ARE PROVIDED IN ACCORDANCE WITH THE REQUIREMENTS OF THE NEW HAMPSHIRE STATUTES APPLICABLE TO ACCIDENT AND HEALTH INSURANCE AND UNDER THE JURISDICTION OF THE NEW HAMPSHIRE INSURANCE COMMISSIONER.

Coverage under this Policy is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Policy annually. The Exchange may refuse renewal under certain conditions.

This product is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield, a stock corporation and licensed Accident and Health insurer in the State of New Hampshire. Benefits are underwritten by Matthew Thornton Health Plan, Inc. Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling the Customer Service number below or on Your Identification Card.

Our toll-free telephone number is 1-855-748-1804
Anthem Blue Cross and Blue Shield is located at:
1155 Elm Street, Suite 200, Manchester, New Hampshire 03101-1505

Welcome!

Welcome to Anthem Blue Cross and Blue Shield! This Policy has been prepared by Us to help explain Your coverage. Please refer to this Policy whenever You require medical 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.

This Policy shall constitute Your entire health benefit plan under which Covered Services and supplies are provided by Us.

This Policy should be read and re-read in its entirety. Since many of the provisions of this Policy are interrelated, You should read the entire Policy to get a full understanding of Your coverage.

Many words used in the Policy have special meanings and start with a capital letter and are defined for You. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Policy also contains **"Limitations and Exclusions,"** so please be sure to read it carefully.

Please contact Our office whenever You have questions, concerns or suggestions. Our Customer Service Representatives are available during business hours to assist You. A representative will ask for the identification number listed on Your Identification Card so that We can locate Your important records and assist You without delay.

How to Get Language Assistance

Anthem is committed to communicating with Our Members about their health coverage, 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.

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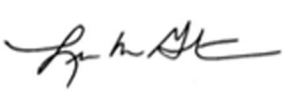
Please call Anthem Blue Cross and Blue Shield at 1-855-748-1804 or Fax Customer Service at 1-855-414-9998.

You can write to Us at this address:

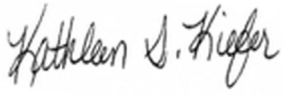
Anthem Blue Cross and Blue Shield
1155 Elm Street
Suite 200
Manchester, New Hampshire 03101-1505

Please visit Anthem's website at **www.anthem.com.**



Lisa M. Guertin

President and General Manager
New Hampshire



Kathleen S. Kiefer

Corporate Secretary

IMPORTANT NOTICE

THIS POLICY DOES NOT INCLUDE PEDIATRIC DENTAL SERVICES. PEDIATRIC DENTAL COVERAGE IS INCLUDED IN SOME HEALTH PLANS, BUT CAN ALSO BE PURCHASED AS A STANDALONE PRODUCT. PLEASE CONTACT YOUR INSURANCE CARRIER OR YOUR PRODUCER, OR SEEK ASSISTANCE THROUGH WWW.HEALTHCARE.GOV. IF YOU WISH TO PURCHASE PEDIATRIC DENTAL COVERAGE OR A STANDALONE DENTAL SERVICES PRODUCT.

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 Policy.
- Work with Your Doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private by following Our privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
    - Our company and services.
    - Our Network of health care Providers.
    - Your rights and responsibilities.
    - The rules of Your health plan.
    - The way Your health plan works.
- Make a complaint or file an Appeal about:
    - Your health plan and any care You receive.
    - Any covered service or benefit decision that Your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.
- Get help at any time, by calling the Customer Service number located on the back of Your Identification Card **(1-855-748-1804)** or by visiting **www.anthem.com.**

  Or contact Your local insurance department:

  NEW HAMPSHIRE

  Phone: 1-800-852-3416
  Write: Life, Accident and Health Consumer Affairs Coordinator
  New Hampshire Insurance Department
  21 South Fruit Street, Suite 14
  Concord, NH 03301

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give Us, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your Policy. This may include information about other health insurance benefits You have along with Your coverage with Us.
- Inform Customer Service if You have any changes to Your name, address or family members covered under Your plan.

If You would like more information, have comments, or would like to contact Us, please go to **www.anthem.com** and select **Customer Support > Contact Us**. Or call the Customer Service number on the back of Your Identification Card **(1-855-748-1804).**

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 Policy, Outline of Coverage or Cost-Sharing Schedule and not by this Member Rights and Responsibilities statement.

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COST-SHARING SCHEDULE

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 "Limitations and Exclusions" section.

Services will only be Covered Services if rendered by Network Providers unless:

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

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 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.**

For a detailed explanation of how Your Calendar Year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

Please Note: If You receive services from an Out-of-Network Provider, except in Emergencies and out-of-area Urgent Care situations, You will be responsible for the service charges.

Plan Features

Deductible	**Network Member Pays**	**Out-of-Network Member Pays**
Individual	$4,000	Not Covered
Family	$8,000	Not Covered
The individual Deductible applies to each covered family member. No one person can contribute more than the individual Deductible amount. Once two (2) 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**	**Out-of-Network Member Pays**
Coinsurance Percentage (unless otherwise specified)	0% Coinsurance	Not Covered

Out-of-Pocket Limit	Network Member Pays	Out-of-Network Member Pays
Individual	$5,700	Not Covered
Family Includes Deductible, Copayments and Coinsurance	$11,400	Not Covered
The individual Out-of-Pocket Limit applies to each covered family member. Once two (2) or more covered family members' Out-of-Pocket Limit combines 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 (1) person can contribute more than the 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 (1-855-748-1804).

Medical Services

Medical Services	Network Member Pays	Out-of-Network Member Pays
Ambulance Services		
Emergency	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence, if an Out-of-Network Provider is used. Additionally, for Emergent services, Out-of-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount.	$0 Copayment 0% Coinsurance	Any balance remaining after the $50,000 per occurrence limit has been met.
Autism Services **Note:** PT/OT/ST services w/autism diagnosis not subject to visit limits.	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Chiropractic Services Copayment applies to the first 3 office visits**, which are not subject to Deductible.** **Please note: This office visit limit is a combined office visit limit which includes PCP and Physical Therapy office visits.** Additional office visits, after the first 3, are subject to both Deductible and Coinsurance. All other Chiropractic services subject to both Deductible and Coinsurance. 12 visits per Calendar Year.	$40 Copayment for first 3 visits 0% Coinsurance 0% Coinsurance	Not Covered Not Covered Not Covered
Doctor Visits **Primary Care Physician (PCP)** Copayment applies to the first 3 PCP office visits**, which are not subject to the Deductible.** **Please note: This office visit limit is a combined visit limit which includes Chiropractic and Physical Therapy office visits.** Additional PCP office visits are subject to both Deductible and Coinsurance. **Specialty Care Physician (SCP)**	$40 Copayment for first 3 visits 0% Coinsurance $0 Copayment 0% Coinsurance	Not Covered Not Covered Not Covered
Durable Medical Equipment Supplies and Prosthetics Coverage for external breast prostheses is limited to 2 prostheses per breast, per Calendar Year. Coverage for post-mastectomy bras is limited to 3 bras per Member, per Calendar Year. Coverage includes wigs and scalp hair prostheses, up to a $350 annual maximum.	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Early Intervention Services	$0 Copayment 0% Coinsurance	Not Covered
Emergency Room Visits (Copayment waived if admitted)	$500 Copayment 0% Coinsurance	$500 Copayment 0% Coinsurance
Urgent Care Center	$50 Copayment 0% Coinsurance	$50 Copayment 0% Coinsurance
Hearing Aid One per each ear, each time a prescription changes, or every sixty (60) months, whichever comes first. Coverage **does not** include cochlear implants.	$0 Copayment 0% Coinsurance	Not Covered
Home Health Care	$0 Copayment 0% Coinsurance	Not Covered
Hospice Care	$0 Copayment 0% Coinsurance	Not Covered
Hospital Services		
Inpatient admission	$500 Copayment, per stay 0% Coinsurance, per stay	Not Covered
Outpatient	$0 Copayment 0% Coinsurance	Not Covered
Infusion Therapy	$0 Copayment 0% Coinsurance	Not Covered
Inpatient Maternity Care	$500 Copayment, per stay 0% Coinsurance, per stay	Not Covered
Mental Health & Substance Abuse		
Inpatient admission	$500 Copayment, per stay 0% Coinsurance, per stay	Not Covered
Outpatient facility	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 0% Coinsurance	Not Covered
Diagnostic Imaging Service and Electronic Diagnostic Tests	$0 Copayment 0% Coinsurance	Not Covered
Advanced Imaging Services	$0 Copayment 0% Coinsurance	Not Covered
Outpatient Therapy Services Cardiac Rehabilitation Therapy Kidney Dialysis in a Hospital or free standing dialysis center. Radiation Therapy	$0 Copayment 0% Coinsurance	Not Covered
Physical Therapy Limited to a maximum of 20 visits per Member, per Calendar Year. Copayment applies to the first 3 office visits, **which are not subject to the Deductible.** **Please note: This office visit limit is a combined visit limit which includes PCP and Chiropractic office visits.**	$40 Copayment for first 3 visits	Not Covered
Additional office visits are subject to both Deductible and Coinsurance.	$0 Copayment 0% Coinsurance	Not Covered
All other Physical Therapy services are subject to both Deductible and Coinsurance.	$0 Copayment 0% Coinsurance	Not Covered
Occupational Therapy Limited to a maximum of 20 visits per Member, per Calendar Year.	$0 Copayment 0% Coinsurance	Not Covered
Speech Therapy Limited to a maximum of 20 visits per Member, per Calendar Year.	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Preventive Care Services Network services required by law are not subject to Deductible. Please see the “Preventive Care” section in Your Policy for a listing of services.	$0 Copayment 0% Coinsurance	Not Covered
Skilled Nursing Facility Limited to a maximum of 100 days per Member, per Calendar Year.	$0 Copayment 0% Coinsurance	Not Covered
Transplant Human Organ & Tissue Coverage is available In-Network only and includes, but is not limited to, Transplant, Transportation and Lodging. **Unrelated Donor Search - $30,000 maximum benefit limit per transplant.**	In-Network Cost Shares may vary depending upon the type of service, as well as the place of service.	Not Covered

Prescription Drugs

Retail Pharmacy Prescription Drugs (up to a 90-day supply)	**Network Member Pays**	**Out-of-Network Member Pays**
Tier 1 (each 30-day supply)	$20 Copayment 0% Coinsurance **Deductible waived**	Not Covered
Tier 2 (each 30-day supply)	$50 Copayment 0% Coinsurance **Deductible waived**	Not Covered
Tier 3 (each 30-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 4 (each 30-day supply) Coverage is limited to those Drugs listed on Our Prescription Drug List (Formulary).	$0 Copayment 0% Coinsurance	Not Covered

Mail Order Prescription Drugs	**Network Member Pays**	**Out-of-Network Member Pays**
Tier 1 (each 90-day supply)	$40 Copayment 0% Coinsurance **Deductible waived**	Not Covered
Tier 2 (each 90-day supply)	$125 Copayment 0% Coinsurance **Deductible waived**	Not Covered
Tier 3 (each 90-day supply)	$0 Copayment 0% Coinsurance	Not Covered

Mail Order Prescription Drugs	Network Member Pays	Out-of-Network Member Pays
Tier 4 (each 30-day supply) Coverage is limited to those Drugs listed on Our Prescription Drug List (Formulary).	$0 Copayment 0% Coinsurance	Not Covered

Pediatric Vision Care Services

We cover the following vision care services for members to the end of the month in which they turn age nineteen (19). **COVERED VISION SERVICES ARE NOT SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.**

Coverage is only provided when services are received from a Blue View Vision Provider. For help in finding a Blue View Vision Provider, call the telephone number listed on the back of Your Identification Card **(1-855-748-1804).**

Pediatric Vision Care (for children up to age 19)	**Network** **Member Pays**	**Out-of-Network** **Payment Allowance**
Routine Eye Exam	$0 Copayment	Not Covered
1 every Calendar Year		
Standard Lenses*		
1 every Calendar Year		
Single Vision	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Progressive	$0 Copayment	Not Covered
Lenticular	$0 Copayment	Not Covered
Note: Lenses include a choice of glass or plastic lenses. Factory scratch coating, standard polycarbonate and standard photochromic lenses, UV coating, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses are provided at no additional cost when received from Network Providers.		
Frames*(formulary) This plan offers a selection of covered frames.	$0 Copayment	Not Covered
1 every Calendar Year		
Contact Lenses*(formulary) This plan offers a selection of covered contact lenses.		
1 every Calendar Year		
Elective (conventional and disposable)	$0; formulary	Not Covered
Non-Elective	$0; formulary	Not Covered

Pediatric Vision Care (for children up to age 19)	**Network** **Member Pays**	**Out-of-Network** **Payment Allowance**
Low Vision		
Comprehensive Low Vision Exam Once every Calendar Year	$0 Copayment	Not Covered
Optical/Non-optical aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year.	$0 Copayment	Not Covered

*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 Share 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.

Section 1: OVERVIEW – HOW YOUR PLAN WORKS

Please see Section 13 for definitions of specially capitalized words.

Headings, Pronouns and Cross-References. Section and subsection headings contained in this Policy are inserted for convenience of reference only, will not be deemed to be a part of this Policy for any purpose, and will not in any way define or affect the meaning, construction or scope of any of the provisions herein.

All pronouns and any variations thereof will be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

In this Policy, You find "cross-references." For example, when You review Section 6, "Covered Services", We suggest that You refer to Section 7, "Limitations and Exclusions." These cross-references are for Your convenience only. Cross-references are not intended to represent all of the terms, conditions and limitations set forth in this Policy.

I. About This Policy

This is Your Policy. It describes a relationship between You, Your Physician and Anthem. Certain rights and responsibilities are also described in this Policy.

Your Cost-Sharing Schedule is an important part of this Policy. It lists Your cost-sharing amounts (Copayments, Deductibles and Coinsurance). Certain Benefit limitations are also shown on Your Cost-Sharing Schedule. Please read Your Policy and the Cost-Sharing Schedule contained within it carefully, because they explain the terms of Your coverage.

II. Your Benefit Options

There is one level of benefit under this Policy:

Network Benefits. With few exceptions (explained in Section 3, "Network Benefits"), You must receive Covered Services from a Network Provider to be eligible for Network Benefits.

Please see Section 3, "Network Benefits", for details about Network Benefits.

III. The Network

The network consists of Network Providers. Network Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care.

Network Providers are Physicians, including primary care providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurse (APRN), and pediatricians) and specialists, hospitals and other health care providers and facilities in the Service Area who have a network payment agreement directly with Anthem to provide Covered Services to Members. Network Providers located in the Service Area are listed in the Provider Directory. Since the printed directory is updated periodically, Your directory book may not always be current at the time you need to arrange for Covered Services. **To locate the most up-to-date information about Network Providers in the Service Area, please go to Anthem's website, www.anthem.com. Or, You may contact Customer Service for assistance. The toll-free number is on Your Identification Card (1-855-748-1804).**

Physicians including primary care providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurse (APRN), and pediatricians), hospitals and other health care providers and facilities *outside the Service* Area that have a payment agreement with the local Blue Cross and Blue Shield Plan (the Local Plan). **To locate Network Providers outside the Service Area, please call the BlueCard® Access Call Center at 1-800-810 BLUE (2583).**

Payment agreements may include financial incentives or risk sharing relationships related to provision of services or referrals to other Network Providers, Out-of-Network Providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Anthem.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. For example, Subcontractors may include but are not limited to, Pharmacy Benefits Managers (PBMs) who manage Prescription Drug benefits. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem's behalf.

The selection of a Network Provider or any other Provider and the decision to receive or decline health care services is the sole responsibility of the Subscriber. Contracting arrangements between the Network Provider and Anthem (or between Network Providers and another Blue Cross and Blue Shield Plan) should not, in any case, be understood as a guarantee or warranty of the professional services of any Provider or the availability of a particular Provider.

Physicians, hospitals, facilities and other Providers who are not Network Providers are Out-of Network Providers.

IV. Services Must Be Medically Necessary

Anthem will pay for Covered Services only if the services are Medically Necessary. This requirement applies to each and every section of this Policy. The definition of Medical Necessity is mandated under New Hampshire law. Anthem may review services after they have been furnished in order to confirm that they were Medically Necessary. Network Providers in the Service Area are prohibited from billing You for care that is not Medically Necessary unless:

- You sign an agreement with the Provider accepting financial responsibility for services, and/or
- The services are not Covered Services or are subject to a limitation or exclusion as described in this Policy.

For services received outside the Service Area, You may be responsible for the full cost of services that are not Medically Necessary.

No coverage is available for services that are not specifically described as Covered Services in this Policy.

Section 2: COST SHARING TERMS

Please see Section 13 for definitions of other specially capitalized words.

Under this Policy, You share the cost of certain Covered Services. Please see Your Cost-Sharing Schedule (enclosed with this Policy) for specific Cost-Share amounts.

You will find some or all of the following terms on Your Cost-Sharing Schedule:

I. Deductible

A Deductible is the amount You owe for health care services that 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 those covered health care services that are subject to the Deductible. The Deductible may not apply to all services. Please refer to Your Cost-Sharing Schedule for Deductible information.

II. Copayment

A fixed amount (for example, $15) You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service.

III. Coinsurance

After any applicable Deductible is met, Anthem pays a percentage of the cost of certain Covered Services. Your share of the costs for a covered health care service is calculated as a percentage of the Maximum Allowed Amount (MAA) for that service (for example, Your cost may be 20% of the MAA). You pay Coinsurance plus any Deductibles You owe. For instance, if the health insurance or plan's MAA for an office visit is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20. The plan pays the rest of the MAA. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments

Coinsurance applies to Covered Services as shown on Your Cost-Sharing Schedule.

IV. Out-of-Pocket Limit

A specified dollar amount of expense incurred for Covered Services in a Calendar Year as listed in the Cost-Sharing Schedule and the Covered Services section of this Policy. Such expense does not include charges in excess of the MAA or any non-covered services. Refer to the Cost-Sharing Schedule and the Covered Services section of this Policy 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 Policy.

V. Out-of-Pocket Costs

In addition to the Cost-Share amounts shown on Your Cost-Sharing Schedule, You are responsible for paying other costs, as follows:

A. Certain **annual coverage limitations may apply under this Policy**. Annual coverage limitations apply to certain Covered Services, as stated on Your Cost-Sharing Schedule and in this Policy. You are responsible for the cost of services that exceed an annual limitation.

Amounts That Exceed the Maximum Allowed Amount (MAA). Covered Services under this Policy are limited to the Maximum Allowed Amount.

Network Providers and BlueCard® Providers agree to accept the MAA as payment in full.

B. **Non-covered or Excluded Services.** You are responsible for paying the full cost of any service that is not described as a Covered Service in this Policy. You are responsible for paying the full cost of any service that is excluded from coverage under this Policy. This applies even if a Physician or other Provider prescribes orders or furnishes the service and even if the service meets Anthem's definition of Medical Necessity.

Section 3: NETWORK BENEFITS

I. Your Primary Care Provider (PCP)

In this Policy, Your Primary Care Provider is called Your PCP. To be eligible for Covered Services, each Member may select a PCP at enrollment time. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians.

To select Your PCP, use the Provider Directory, which is available online at **www.anthem.com.** Or, call Customer Service for assistance. The toll-free telephone number is **1-855-748-1804.**

Your PCP is a Physician who becomes familiar with Your medical history, furnishes Your primary care and coordinates other health care services. Always talk to Your PCP *before* You receive health care services. If You need specialized care, Your PCP may coordinate Your care by working with the hospitals, specialists and suppliers in the Network and by authorizing any required Referral for Network Services *in advance*.

Information about Network practitioners and facilities is available in the online network directory at **www.anthem.com.** You can find information such as the practitioner's location and professional qualifications. If You do not have access to the website or need help choosing a Doctor who is right for You, call Customer Service. Anthem's toll-free number is **1-855-748-1804.** TTY/TDD services are also available by dialing 711. A special operator will contact Anthem to help with Member needs.

When You Need Primary Care Services

Call Your Primary Care Provider's (PCP) or Network Provider's office. When You call to make an appointment:

- Tell them You are an Anthem Member.
- Have Your Member Identification Card (Member ID Card) handy. They may ask You for Your Member Identification number, or office visit Copayment.
- Tell them the reason for Your visit.

When You go for Your appointment, bring Your Member ID Card.

When You need care after normal office hours

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

II. The Network

Network Providers are Physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN) and pediatricians) and specialists, hospitals and other health care Providers and facilities that have a network payment agreement directly with Anthem Health Plans of New Hampshire, Inc., (Anthem) to provide Covered Services to Members. Network Providers are listed in the Provider Directory. Since the directory is updated periodically, Your directory book may not always be current at the time You need to arrange for Covered Services.

To locate the most up-to-date information about Network Providers, please go to Anthem's website, www.anthem.com. Or, You may contact Customer Service for assistance. The toll-free telephone number is 1-855-748-1804.

Network Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care.

Payment agreements may include financial incentives or risk sharing relationships related to provision of services or Referrals to other Network Providers, Out-of-Network Providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Anthem.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. For example, Subcontractors may include but are not limited to Pharmacy Benefits Managers (PBMs) who manage Prescription Drug benefits. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem's behalf.

The selection of a Network Provider or any other Provider and the decision to receive or decline to receive health care services is the sole responsibility of the Member. Contracting arrangements between Network Providers and Anthem should not, in any case, be understood as a guarantee or warranty of the professional services of any Provider or the availability of a particular Provider.

Physicians, hospitals, facilities and other providers who are not Network Providers are Out-of - Network Providers.

III. 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 Your 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 listed on the first page of this Policy or on the back of Your Member Identification Card **(1-855-748-1804).** TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

Please note that We have several networks, and that a Provider that is a Network Provider for one plan may not be a Network Provider for another. Be sure to check Your Identification Card or call Customer Service to find out which network this health benefit plan uses.

First – Make an Appointment for 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; and
- 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 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 mental health and/or a substance abuse care 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 first page of this Policy or on the back of Your Identification Card **(1-855-748-1804).**

Section 4: ABOUT MANAGED CARE

This is a Managed Care Plan. This means that Anthem (or a designated administrator) works with You and Your health care Providers to determine that Your Covered Services are Medically Necessary. The definition of Medical Necessity is mandated under New Hampshire law.

A Member's right to Covered Services provided under this Policy is subject to certain policies or guidelines and limitations, including, but not limited to, Anthem's medical policy and guidelines for Precertification (including Anthem's Concurrent Review process) and Case Management. Health care management guidelines, their purposes, requirements and effects on Covered Services, are described in this section and throughout this Policy. Failure to follow these guidelines and procedures for obtaining Covered Services will result in reduction or denial of benefits, as stated in this Policy.

I. Your Role

You play an important role in this Managed Care plan. As a Member, You should become familiar with and follow the rules in this Policy described in Sections 1 through 5. Knowing and following the rules is the best way for You to enjoy all of the advantages of this Policy.

Your suggestions about how to improve are important to Us. Please contact Customer Service at the toll-free telephone number on Your Identification Card **(1-855-748-1804)** to let Us know about Your suggestions. Please see Section 10: Member Satisfaction Services and Appeal Procedure for Our contact information and how to inform Us about Your suggestions.

II. The Role of Network Providers

Network Providers will work together to help make sure that You have access to the health care services that You need. Your Network Physician can best oversee and coordinate Your care if You choose to contact him or her before You receive health care services. You access the higher level of coverage under this Policy by seeking care from a Network Provider.

Most often, Your Network Physician will provide Your routine or urgent care directly. If Your Physician determines that You require specialized care that falls outside his or her clinical expertise or services offered, Your Physician will refer You to another Provider. With few exceptions, You will be referred to a Network Provider.

III. Anthem's Role

As the administrator of benefits under this Policy, Anthem's Medical Director and Medical Management division play an important role in the management of Your benefits. Some examples are:

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/ Investigative 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.

Requesting Approval for Benefits

Your Policy includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by Your Policy. 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 where they are performed. Covered Services must be Medically Necessary for benefits to be covered.

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 prescribed or asked for is not Medically Necessary, as it does not meet the definition of Medically Necessary listed in Section 13: Definitions.

If You have any questions about the information in this section, You may call the Customer Service phone number on the first page of this Policy or on the back of Your Identification Card **(1-855-748-1804).**

IV. 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 forty-eight (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 Policy 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 Policy or is Experimental/Investigative as that term is defined in this Policy.

- **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 eighteen (18) years of age or older.

Who is Responsible for Precertification	
Services given by a Network Provider:	Services given by a BlueCard®/Out-of-Network Provider:
Provider	Member has no benefit coverage for an Out-of-Network Provider unless: • You get authorization to use an Out-of-Network Provider before the service is given; or • For Emergency admissions, You, Your authorized representative or Doctor must tell Us within forty-eight (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. 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 Investigative as that term is defined in the Policy otherwise. Your Policy takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination 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 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 by contacting Customer Service at the number on the first page of this Policy or on the back of 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 the plan's Members.

V. Request Categories

- **Emergent** - 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 health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.

- **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.

- **Retrospective** - A request for approval that is made 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, accuracy of documentation, coding or adjudication of payment.

VI. 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 Policy was issued other state-specific requirements may apply. You may call the phone number on the first page of this Policy or on the back of Your Identification Card for more details **(1-855-748-1804).**

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	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 Emergent 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 Emergent 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-Emergent	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. A written notice will follow the verbal notice within two (2) business days.

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:

a. You must be eligible for benefits;
b. Premium must be paid for the time period that services are given;
c. The service or supply must be a covered benefit under Your Policy;
d. The service cannot be subject to an Exclusion under Your Policy; and
e. You must not have exceeded any applicable limits under Your Policy.

VII. Health Plan Individual Case Management

Our health plan's case management (Case Management) programs 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 plan. 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.

A. Determinations about Medical Necessity. Anthem reserves the right to make a final determination about whether or not a service is Medically Necessary. Please see Section 13 "Definitions" for a definition of "Medically Necessary."

B. Determinations about Experimental/Investigative Services. Anthem makes determination about whether or not a service is Experimental/Investigative based on the terms of Section 7 article II, "Experimental/Investigative Services." Anthem's medical policy assists in Anthem's review regarding Experimental/Investigative Services and other issues. Anthem's medical policy reflects the standards of practice and medical interventions identified

as reflecting appropriate medical practice. However, the benefits, exclusions and limitations stated in this Policy take precedence over medical policy.

You have the right to appeal benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigative services. Please see Section 10 "Member Satisfaction Services and Appeal Procedure" for complete information.

C. Review of New Technologies. Anthem reserves the right to make final determinations about coverage for new technologies. We evaluate new medical technologies to define medical effectiveness and to determine appropriate coverage. Our evaluations are focused on the following factors:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve net health outcomes.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigative setting.
- The technology must not be an Experimental service.

Section 5: URGENT AND EMERGENCY CARE

This section is a guide to help You determine when You may need to go directly to a hospital for Emergency Care.

I. Urgent Care

Whenever possible, contact a Network Provider for direction when You need urgent care. Examples of such conditions are: sprain, sore throat, rash, earache, minor wound, moderate fever or abdominal or muscle pain.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with Your Physician before You seek care. In an emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency medical condition means 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:

1. 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;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency services means, 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.

Stabilize, with respect to an emergency medical condition, means:

To provide such medical treatment of the condition as may 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 deliver (including the placenta), if there is inadequate time to affect 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.

Examples of conditions or symptoms that may require Emergency Care are: suspected heart attack or stroke, a broken bone, uncontrolled bleeding, unconsciousness (including as a result of drug overdose or alcohol poisoning) or You are at serious risk of harming Yourself or another person.

Emergency Care may be furnished in a licensed hospital emergency room. When Medically Necessary, You may be admitted to a hospital as a bed patient for Emergency Care. Network benefits are available when You receive Emergency Care from a Network Provider. Network Providers accept the Maximum Allowed Amount as payment in full.

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room, provided that Your condition meets the definition of Emergency Care as stated in article II, "Emergency Care", above.

Your share of the cost for use of the emergency room is shown on Your Cost-Sharing Schedule.

IV. Emergency Admissions

Your share of the cost for Inpatient Services is shown on Your Cost-Sharing Schedule.

A. **Medical/Surgical Admissions for Emergency Care.** If You are admitted to a hospital as a bed patient for inpatient medical/surgical Emergency Care You (or someone acting for You) must **contact Anthem for Precertification within forty-eight (48) hours** (or on the next business day, whichever is later). Please call Anthem at **1-800-531-4450** for Precertification.

B. No benefits will be available if Your admission was not Medically Necessary. You may be responsible for the full cost of care that is not Medically Necessary, as determined by Anthem.

If You are unable to call within forty-eight (48) hours, Anthem will determine if Your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing Your admission records.

Precertification requests for Inpatient admissions are Pre-Service Claims. Please see Section 8, "Claims Procedures", for more information about Anthem's Claim Procedures.

Please see Section 4, "About Managed Care", for complete information about Precertification.

V. Limitations

In addition to the Limitations and Exclusions listed in Section 7, "Limitations and Exclusions", the following limitations apply to Emergency Care:

A. "Follow-up" care is any related Covered Service that You receive after Your initial Emergency Care. To be eligible for Network benefits for medical/surgical conditions, Your follow-up care must be furnished by a Network Provider.

B. When determining whether or not Your services meet the definition of Emergency Care, Anthem will consider not only the outcome of Your emergency room visit or hospital admission, but also the symptoms that caused You to seek the care. To make this determination, Anthem reserves the right to review medical records after You have received Your services.

Emergency Care does not include routine or elective care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Elective care is care that can be delayed until You can contact Your Physician or Anthem for direction. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care does not include any service related to or resulting from routine or elective care.

C. No benefits are available for care related to, resulting from, arising from or provided in connection with non-covered services or for complications arising from non-covered services, even if the care meets Anthem's definitions of Emergency Care and/or Medical Necessity.

Section 6: COVERED SERVICES

This section describes Covered Services for which Anthem provides benefits. All Covered Services must be furnished by a Network Provider according to the plan guidelines stated in this Policy. Preventive Care services are listed in article II A, "Outpatient Services" (below). All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, or injury, or for maternity care. Otherwise, no benefits are available. The Covered Services described in this section are available for treatment of the diseases and ailments caused by obesity and morbid obesity, as required by New Hampshire law. Please remember the plan guidelines are explained in Sections 1 through 5. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All benefits are subject to the exclusions and limitations, terms and provisions described in Section 7, "Limitations and Exclusions", and elsewhere in this Policy.
- To receive maximum benefits for Covered Services, You must follow the terms of this Policy, including, when applicable, obtaining any required Precertification.
- Covered Services are based on Maximum Allowed Amount for such services. Deductible amounts are limited to the Maximum Allowed Amount. Coinsurance is a percentage of the Maximum Allowed Amount. No coverage is available for amounts that exceed Anthem's Maximum Allowed Amount.
- Anthem's payment for Covered Services will be limited by any Copayment, Deductible, Coinsurance or annual benefit limit applicable to Your Policy. Such limitations are stated on Your Cost-Sharing Schedule and in this Policy.
- Covered Services may be payable subject to an approved treatment plan created under the terms of this Policy.
- 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.
- Anthem makes determinations about Precertification, Medical Necessity, Experimental/Investigative services and new technology based on the terms of this Policy, including, but not limited to the definition of Medical Necessity. The definition of Medical Necessity is mandated under New Hampshire law and is stated in Section 13, "Definitions." Anthem's medical policy assists in making these determinations. Our medical policy reflects the standards of practice and medical interventions identified as appropriate medical practice. However, the Covered Services, Limitations and Exclusions stated in this Policy take precedence over medical policy. You have the right to appeal benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 10, "Member Satisfaction Services and Appeal Procedure", for complete information.

Please Note:

- In this section, We often refer to Your Cost-Sharing Schedule. Your Cost-Share amounts and important limitations are shown on the Cost-Sharing Schedule (enclosed with this Policy).
- The highest level of benefits (Network Benefits) is available when You receive Covered Services from a Network Provider. Please see Section 3, "Network Benefits", for a complete description of Your benefit options.
- Please remember that You must call Anthem to obtain Precertification before You receive certain Covered Services. Benefits will be reduced if You do not follow Precertification rules. Benefits may be denied if non-approved services are not Medically Necessary, as

determined by Anthem. Please see Section 4, “About Managed Care”, for more information. Precertification rules for Emergency Care are stated in Section 5, “Urgent and Emergency Care.”

I. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. Coverage includes the following:

A. Care in a Short-term General Hospital - semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Short-term General Hospital while You are a bed patient. Custodial Care is not covered. Please see Section 7, “Limitations and Exclusions”, for a definition of Custodial Care.

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility - semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while You are a bed patient (Inpatient). Benefits may be limited to a certain number of Inpatient days per Member, per Year, as shown on Your Cost-Sharing Schedule. Any combination of days in a Skilled Nursing or Physical Rehabilitation Facility counts toward the limit. When counting the number of Inpatient days, the day of admission is counted but the day of discharge is not. Custodial Care is not covered.

C. Inpatient Physician and Professional Services - physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests. Benefits for Inpatient medical care are limited to daily care furnished by the attending Physician, unless another Physician’s services are Medically Necessary. The definition of Medical Necessity is stated in Section 13, “Definitions.” For Skilled Nursing or Physical Rehabilitation Facility admissions, benefits may be limited to a certain number of Inpatient days per Member, per Year, as shown on Your Cost-Sharing Schedule. Any combination of days in a Skilled Nursing or Physical Rehabilitation Facility counts toward the limit.

Please see article VI, “Surgery for Conditions Caused by Obesity” (below in this section), for related information about Inpatient services. Also, please see Section 7, “Limitations and Exclusions”, for important Limitations and Exclusions that may apply to Inpatient Services.

II. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care

1) In general the term “Preventive Care” under this Policy refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition. Benefits and services will be considered under the Diagnostic Services benefit.

2) Preventive Care Services in this section shall meet requirements as determined by Federal and state law. Many preventive care services are covered by this policy with no Deductible, Copayments or Coinsurance from the Member as explained in Your Cost-Sharing Schedule. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

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

Examples of these services are screenings for:

1) Breast cancer;

2) Cervical cancer;

3) Colorectal cancer;
4) High Blood Pressure;
5) Type 2 Diabetes Mellitus;
6) Cholesterol;
7) Child and Adult Obesity;
8) Hearing screening;
9) Vision screening;
10) Tobacco use: related screening and behavioral counseling;
11) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
12) 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
13) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration including the following:
    a) Contraceptive services for women. As required by law, contraceptive services are covered at no cost for women with reproductive capacity. This benefit includes at least one form of contraception in each of the contraceptive methods identified for women by the U.S. Food and Drug Administration (FDA). FDA-identified methods include, but are not limited to barrier methods, hormonal methods, implanted devices and sterilization procedures. Education and counseling, Outpatient consultations, examinations and medical services related to the use of contraceptive methods are also covered at no cost under this section.
    b) Women's contraceptives, sterilization procedures, and counseling. This includes Generic and single source Brand-Name Drugs (brands without a generic), obtained from a Participating Pharmacy, as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. For Brand-Name contraceptives where a Generic equivalent is available, the Brand-Name contraceptives will only be covered at no cost when determined to be 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 Drug" section.
    c) Breastfeeding support, supplies, and counseling. To obtain Network Benefits, breast pumps and supplies must be received from Our Network Provider. If another Out-of-Network Provider is used, benefits will be covered as an Out-of-Network Service. Benefits for breast pumps are limited to one per Calendar Year or as required by law.
    d) Gestational diabetes screening.
    e) Pre-natal care.

You may call Customer Service using the toll-free phone number listed on the first page of this Policy and on the back of Your Identification Card **(1-855-748-1804)** for additional information about these services.

B. Medical/Surgical Care in a Physician's Office. In addition to Preventive Care commonly provided in a Physician's office (see item A, "Preventive Care" above), the following services are covered:

1. Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections) and travel immunizations, medical treatments (including allergy treatments) furnished in a Physician's office, including services furnished at a Walk-In Center.

   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.

2. Laboratory and x-ray tests (including allergy testing and ultrasound).
3. CT scan, MRI, chemotherapy.
4. Medical supplies and drugs administered in an office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts administered or applied in a Physician's office for the prevention of disease, illness or injury or for therapeutic purposes. No benefits are available for fertility hormones or fertility drugs. Hormones, insulin and Prescription Drugs purchased at a Physician's office, for use outside the office, are not covered under any portion of this Policy. Medical equipment, supplies and prosthetics purchased for use outside a Physician's office are not covered under this Section. Please see Medical Equipment, Supplies and Prosthetics as described in Section 6, "Covered Services", under article V, for coverage information.
5. Diabetes Management Programs. To be eligible for benefits, Covered diabetes management programs must be ordered by Your Physician and furnished by a certified, registered or licensed health care expert in diabetes management. Covered Services include:

   - Individual counseling visits;
   - Group education programs and fees required to enroll in an approved group education program; and
   - External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see article V, "Home Health Care", under item H, "Durable Medical Equipment", for information about coverage for external insulin pumps.
   - Screenings for gestational diabetes are covered under "Preventive Care."
   - For information about diabetes education programs or Network Diabetes Education Providers, visit Anthem's website at **www.anthem.com,** or call Customer Service. The toll-free phone number is on the first page of this Policy and on the back of Your Identification Card **(1-855-748-1804).**
   - In addition to the Limitations and Exclusions listed in Section 7, "Limitations and Exclusions", the following limitations apply to diabetes management services:
   - In the Service Area, benefits are limited to Covered Services furnished by a Network Diabetes Education Provider. Outside the Service Area, Covered Services must be furnished by a certified, registered or licensed health care expert in diabetes management.

- Benefits are available for fees required to enroll in an approved group education program. No benefits are available for costs related to materials, activities or supplies in addition to the enrollment fee.
- Insulin, diabetic medications, blood glucose monitors external insulin pumps and diabetic supplies are not covered under this subsection. Please see article V, "Home Health Care", under item G, "Durable Medical Equipment" and under item H, "Medical Supplies", for information about diabetic supplies.
- Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see Number 8, "Nutrition Counseling" below). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Policy.

However, coverage is available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see article VI, "Surgery for Conditions Caused by Obesity."

6. Nutrition counseling by a registered dietitian practicing independently or as part of a Physician practice or Outpatient hospital clinic. *Coverage may be limited as shown on Your Cost-Sharing Schedule.*

   Benefits are available for weight management counseling provided as part of a covered diabetes management program. No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Policy. However, coverage is available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

   For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see article VI, "Surgery for Conditions Caused by Obesity."

C. Outpatient Facility Care: in the Outpatient Department of a Hospital, Ambulatory Surgical Center, or Hemodialysis Center or Birthing Center. In addition to Preventive Care commonly provided in an Outpatient facility (see item A ,"Preventive Care" (above), benefits are available for Medically Necessary facility and professional services in the Outpatient department of a Short-term General Hospital, Ambulatory Surgical Center, or Hemodialysis Center or Birthing Center. Coverage includes the following:

1. Medical exams and consultations by a Physician.
2. Operating room for surgery or delivery of a baby.
3. Physician and professional services: surgery, anesthesia, delivery of a baby, or management of therapy.
4. Hemodialysis, chemotherapy, radiation therapy, infusion therapy.
5. Medical supplies, drugs, other ancillaries, facility charges for observation (observation is a period of up to twenty-four (24) hours during which Your condition is monitored to determine if Inpatient care is Medically Necessary).
6. Diagnostic Services - Your plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Network Provider and include diagnostic services ordered before a surgery or a Hospital admission. Benefits include the following services:

   a) Diagnostic Laboratory and Pathology Services

b) 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.

c) 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.

Also, see article III, “Outpatient Physical Rehabilitation Services” (below).

Please Note: Ambulatory Surgical Centers and Birthing Centers must have a written payment agreement with Anthem or their local Blue Cross and Blue Shield plan. Otherwise, the center is not a Network Provider and no benefits will be available for services provided to You in the facility. This exclusion applies even if the care is prescribed by a Network Provider and meets Anthem’s definition of Medical Necessity.

D. Emergency Room Visits for Emergency Care. Covered Services are shown on Your Cost-Sharing Schedule. Please see Section 5, “Urgent and Emergency Care”, for important guidelines about Emergency Care.

E. Ambulance Services (Air, Ground and Water). 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 Out-of-Network Hospital to a 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.

Out-of-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 Us.

Air and Water Ambulance

Air ambulance services are subject to Medical Necessity review by Us. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency hospital to hospital transports must be Prior Authorized.

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.

F. 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.

G. Telemedicine Services. Telemedicine is the delivery of Covered Services by a Network Provider to a Member by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment without in-person contact between the Provider and Member. Telemedicine does not include the use of audio-only telephone or facsimile.

Benefits are available for telemedicine service provided that all of the following conditions are met:

- The services must be furnished by Your PCP or approved in advance by Your PCP's Referral,
- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and
- The services must be Medically Necessary as defined in Section 13 of this Policy, and
- Both the Network Provider and the Member must be present and participating during a telemedicine services.

Except as stated above, no benefits are available for telemedicine services.

Cost-Sharing amounts for Covered telemedicine Services are the same as for similar services as shown on Your Cost-Sharing Schedule.

The Maximum Allowed Amount for telemedicine services includes the Provider's professional services and costs associated with operating the Provider's practice. Unless additional benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional benefits are available for costs such as, but not limited to a Provider's or Member's telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including but not limited to electronic/internet service provider costs.

H. Applied Behavior Analysis (ABA) for Pervasive Developmental Disorder or Autism. Applied Behavior Analysis is covered to treat pervasive developmental disorders or autism. Benefits may be limited as shown on Your Cost-Sharing Schedule. Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

To be eligible for coverage, Applied Behavior Analysis must be furnished by an individual who is professionally certified by a national board of behavior analysts or the services must be performed under the supervision of a person professionally certified by a national board of behavior analysts. Otherwise, no benefits are available for Applied Behavior Analysis.

Except as stated in this subsection, no benefits are available for Applied Behavior Analysis.

I. Dental Services. For Medically Necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is received or authorized within three (3) months of the date of the injury. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit and consistent with terms and conditions of this Policy applicable to medical/surgical services.

Additionally, please note benefits are available for hospital facility charges (inpatient or outpatient), surgical day care facility charges and general anesthesia furnished by a licensed anesthesiologist or anesthetist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia benefits are:

- Children under the age of six (6). The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's PCP must determine in advance that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition. Anthem must approve the care in advance.
- Members who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Member's PCP and Anthem must approve the services in advance.

No benefits are available for a non-covered dental procedure, even when Your Physician and Anthem authorize hospitalization and anesthesia for the procedure.

J. Temporomandibular Joint (TMJ) and Craniomandibular Joint Services. Benefits are available for the care of temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

III. Outpatient Physical Rehabilitation Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy, Speech Therapy and Habilitative Services. In an office or in the Outpatient department of a Short-term General Hospital or Skilled Nursing Facility or Physical Rehabilitation Facility, b*enefits may be limited, as shown on Your Cost-Sharing Schedule*.

Physical therapy must be furnished by a licensed physical therapist. Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no benefits are available.

Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions during acute care stage of an illness or injury. Otherwise, no benefits are available. Coverage for speech therapy is limited to the following speech therapy services:

1. an evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary; and
2. individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

Services must provide significant improvement within a reasonable and generally predictable period of time. Services may require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. Non-covered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, voice fitness or to reinforce lifestyle changes, including but not limited to lifestyle changes affecting the voice. Such on-going services are not covered, even if ordered by Your Physician or supervised by skilled program personnel. In addition to the limitations and exclusions listed in Section 7, “Limitations and Exclusions”, of Your Policy, no benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No benefits are available for educational reasons, except as stated below, in article III C, “Early Intervention Services.”

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs, provided that all of the following terms are met:

Your participation must be approved by a Physician’s order in advance. The program must meet Anthem’s standards for cardiac rehabilitation. Please call Anthem at **1-800-531-4450** to determine program eligibility.

A Member’s medical history must include at least one of the following conditions or procedures:

- Acute Myocardial Infarction (M.I. or heart attack);
- Coronary Artery Bypass Graft (CABG) surgery;
- Percutaneous Transluminal Coronary Angioplasty (PTCA);
- heart valve surgery;
- heart transplantation;
- stable angina pectoris; or
- compensated heart failure.

Covered Services are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three (3) months after one of the above conditions is diagnosed or one of the above procedures is completed. The program must be completed within six (6) months of the diagnosis or procedure.

No benefits are available for portions of a cardiac rehabilitation program beyond the intensive rehabilitation phase. Non-covered services include on-going or life-long exercise and education programs intended to maintain fitness or to reinforce lifestyle changes. Such on-going services are not covered, even if ordered by Your Physician or supervised by skilled program personnel.

C. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member's third (3rd) birthday. Eligible Members are those with significant functional physical or mental deficits due to a developmental disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care and psychological counseling provided by Eligible Mental Health and Substance Abuse Providers such as Clinical Social Workers. Physical, speech and occupational therapy visits, which are provided as part of Early Intervention Services, do not count toward any annual visit limits that may otherwise apply.

IV. Home Health Care

Benefits are available for Medically Necessary Home Health Care. Covered Services are limited to the following:

A. Physician Services. Physician visits to Your home or place of residence to furnish medical/surgical care that is the same or similar to services ordinarily provided in an office setting.

B. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by a Network or BlueCard® Home Health Agency in Your home or other place of residence. Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for You to travel from Your home to another treatment site.

Covered Services are limited to the following:

1) Part-time or intermittent skilled nursing care by (or under the supervision of) a Registered Nurse.

2) Part-time or intermittent home health aide services that consist primarily of caring for You under the supervision of a Registered Nurse.

3) Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary, as determined by Your Physician and Anthem's case manager. For example, if You are confined to bed rest or Your activities of daily living are otherwise restricted by order of Your Physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the medical necessity of such services, Your Physician will consult with Anthem's case manager.

4) Physical, occupational, or speech therapy services provided by a Home Health Agency do not count toward the annual visit limits that may otherwise apply to outpatient physical rehabilitation services described in article III A, "Outpatient Physical Rehabilitation Services", above.

5) Non-prescription medical supplies and drugs. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription Drugs, certain intravenous solutions and insulin are not included.

C. Hospice Care. 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 Cost-Sharing Schedule 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.

In order to receive Hospice benefits: (1) Your Physician and the Hospice Medical Director must certify that You are terminally ill and generally have less than six (6) months to live, and (2) Your Physician must consent to Your care by the Hospice and must be consulted in the development of Your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

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 Policy, are provided as set forth in other parts of this Policy.

D. Infusion Therapy. Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy Provider. Covered Services are:

1. Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy.
2. Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients.
3. Associated supplies and portable, stationary or implantable infusion pumps.

Please see Medical Equipment, Supplies and Prosthetics as described in Section 6, “Covered Services”, under article V, for information about enteral pumps and related equipment.

E. Medical Equipment, Supplies and Prosthetics. Benefits are available for Durable Medical Equipment (DME), medical supplies and prosthetic devices. To be eligible for Network Benefits, Covered Services must be ordered in advance by Our Physician and furnished by a Network Provider. To be eligible for Out-of-Network Benefits, Covered Services must be ordered by a Physician and furnished by a licensed durable medical equipment, medical supplies and prosthetic devices Provider. Under Out-of Network Benefits, You may be responsible for paying the difference between the Maximum Allowed Amount and the charge, as explained in Section 2, “Cost-Sharing Terms of Your Policy.”

Durable Medical Equipment, supplies and prosthetics may be subject to Deductible and/or Coinsurance. Please see Your Cost-Sharing Schedule for any Cost-Sharing amounts that may apply.

F. Enteral Formula and Modified Low Protein Food Products. Benefits are available for enteral formulas required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for enteral formulas and for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. To be eligible for Benefits, Your Physician must issue a written order stating that the enteral formula and/or food product is:

- needed to sustain life;
- Medically Necessary; and
- the least restrictive and most cost-effective means for meeting Your medical needs.

G. Durable Medical Equipment (DME). In order to be Covered DME, equipment must meet all of the following criteria:

- medical equipment primarily and customarily used for a medical purpose;
- not disposable;
- can withstand repeated use and is appropriate for use in the home; and
- is useful only for a specific illness or injury that a Physician has diagnosed or suspects.

Examples of DME include, but are not limited to: crutches, apnea monitors, oxygen and oxygen equipment, wheel chairs, special hospital type beds or home dialysis equipment and enteral pumps and related equipment of Members who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

Benefits are also available for orthopedic braces for support of a weak portion of the body or to restrict movement in a diseased or injured part of the body.

Benefits are available for one hearing aid per ear, each time a hearing aid prescription changes, or every sixty (60) months, whichever comes first. Coverage includes related services necessary to assess, select, and fit the hearing aid. Please see Your Cost-Sharing Schedule for any Cost-Share amounts or limits that may apply.

H. Medical Supplies. Covered medical supplies are small, often disposable items used to treat an illness or injury that a Physician has diagnosed. A medical supply must be appropriate for Your diagnosis and useful only for a specific illness or injury.

Examples of medical supplies include, but are not limited to: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of Your eye has been surgically removed or is congenitally absent.

Diabetic medical supplies are covered for Members who have diabetes. Examples of covered diabetic medical supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this policy when diabetic supplies are purchased from a licensed durable medical equipment provider.

I. Prosthetic Devices. Covered prosthetic devices replace an absent body part or replace the function of a permanently impaired body part. Examples of prosthetic devices include, but are not limited to: prosthetic limbs and external post-mastectomy breast prostheses.

The MAA for breast prostheses includes the cost of fitting for the prosthesis. Benefits are also available for post-mastectomy bras worn with breast prosthesis. See Your Cost-Sharing Schedule for the benefit frequencies and Your Cost-Share amounts.

Scalp Hair Prostheses (wigs). A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for You. Benefits are available for scalp hair prostheses for Members who have suffered permanent hair loss as a result of alopecia areata, alopecia totalis, or as a result of accidental injury.

Benefits are also available for scalp hair prostheses worn for hair loss suffered as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia.

To be eligible for benefits, Your Physician must state in writing that the prosthesis is Medically Necessary. You must submit Your Physician's statement with Your claim.

Scalp hair prostheses are not covered for temporary hair loss except as described above, or for male pattern baldness.

J. Limitations. The following limitations apply, whether You choose Network Benefits or Out-of-Network Benefits and are specific to this policy:

- Whether an item is purchased or rented, benefits are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount for the least expensive service that meets Your medical needs. If Your service is more

costly than is Medically Necessary, You will be responsible for paying the difference between the Maximum Allowed Amount for the least expensive and the charge for the more expensive service.

- If You rent or purchase equipment and Anthem pays benefits equal to the Maximum Allowed Amount, no further benefits will be provided for rental or purchase of the equipment.
- Anthem reserves the right to determine if equipment should be rented instead of purchased. For example, if Your Physician prescribes a hospital bed for short-term home use, Anthem will require that the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, benefits are limited to what Anthem would pay for rental, even if You purchase the equipment. You will be responsible for paying the difference between the Maximum Allowed Amount for rental and the charge for purchase.
- Burn garments (or burn anti-pressure garments) are covered only when prescribed by Your Physician for treatment of third degree burns, deep second degree burns or for areas of the skin which have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.
- Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered only when prescribed by Your Physician for treatment of lymphedema or venous stasis. A pressure degree of 25 mm Hg must be Medically Necessary. Otherwise, gradient pressure aids are not covered. Anti-embolism stockings are not covered. Inelastic compression devices are not covered.

K. Exclusions. Benefits are not available for the following items or services. These services are not covered even if You receive the service from Your Physician or according to Your Physician's order. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem has the final authority for determining if services or supplies are Medically Necessary Covered Services.

- Convenience items such as, but not limited to: telephone and television rental charges in a hospital, or any personal comfort item, air conditioners, air purifiers, dehumidifiers, room vaporizers, room/central heating humidifiers.
- Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification.
- Special furniture, such as seat lift chairs, stair chair elevators, back chairs, special tables and posture chairs.
- Sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in item I, "Prosthetic Devices" (above).
- Non-prescription supplies, first aid supplies, ace bandages, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs.
- Bath seats, whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans, bed boards, bed tables, or bed support devices of any type, cervical pillows.
- Heat lamps, heating pads, hydrocollator heating units, hot water bottles, batteries, sunglasses.

- Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment or exercise equipment, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device.
- Cranial helmets intended to change the shape of a child's head, safety equipment such as belts, harnesses or restraints.
- Self-monitoring devices except as stated in item H, "Medical Supplies" (above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment.
- Dentures, orthodontics, dental prosthesis and appliances.

V. Reconstructive Surgery

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 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 Policy.

Please 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 the following reconstructive services in the manner chosen by the patient and the physician:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance.

Additionally, coverage is available for Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

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

VI. Surgery for Conditions Caused by Obesity

Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. Anthem's definition of Medical Necessity is found in Section 13, "Definitions." When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons. Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of this Policy, even if the surgery, service or program is ordered by Your Physician or performed or ordered by another Network Provider. This exclusion applies even if the surgery, service or program meets Anthem's definition of Medical Necessity. Except as stated in this subsection, no benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

Please see "diabetes management" and "nutrition counseling", in article II, for information about benefits for non-surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

VII. 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 Cost-Sharing Schedule 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 (PBM) from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated PBM.

Prescription Drug List

We also have a Prescription Drug list, (a Formulary), which is a list of Food and Drug Administration (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 call Customer Service at the telephone number on the back of Your Identification Card **(1-855-748-1804) or visit us online at anthem.com/NHSelectdrugtier4.**

We retain the right, at Our discretion, to decide coverage for doses and administration methods (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 plans. 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-Name 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 **anthem.com/NHSelectdrugtier4.**

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 twenty-four (24) hours of receiving Your request. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds forty-eight (48) hours. 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 twenty-four (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 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 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 twenty-four (24) hours of receiving Your request. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds forty-eight (48) hours. 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 twenty-four (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 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 Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin, 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. However, under the "Preventive Care" benefit coverage is available for *Generic drugs* only, purchased from a Network Pharmacy, unless there is no Generic equivalent or the contraceptives are determined to be Medically Necessary. When Generic equivalents are available and prescription Brand-Name contraceptives are not Medically Necessary, Brand-Name contraceptives will not be covered under the "Preventive Care" benefit. They will be covered under Your "Prescription Drug" benefit and subject to any applicable Policy Cost-Shares. Please see the "Preventive Care" benefit section for more details.
- Flu Shots (including administration).
- Prescription Drugs that help You stop smoking or reduce Your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit when furnished by a Network Pharmacy.
- FDA approved smoking cessation products, including OTC nicotine replacement products, when obtained with a Prescription for a Member age eighteen (18) or older. These products will be covered under the "Preventive Care" benefit.

Retail or Home Delivery (Mail Order) Pharmacy

Your benefit program includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. We use the 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.

Certain contracted New Hampshire Retail Pharmacies can fill Your prescription at the same Copayments that apply to the Mail Order Pharmacy level of benefits, for up to a ninety (90)-day supply. Please ask Your Pharmacy if they offer this special arrangement or call Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** for a list of Retail Pharmacies that offer the Mail Order Pharmacy level of benefits. In addition, please review the "Maintenance Medication - Home Delivery Pharmacy" section below for instructions on how to purchase Your maintenance medications at a Retail Pharmacy.

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 Cost-Sharing Schedule 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 thirty-one (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 Pharmacy

If You are taking a Maintenance Medication, You may get the first medication supply plus one additional refill of the same Maintenance Medication at Your local Retail Pharmacy. You must contact the Home Delivery Pharmacy before the second refill and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each Year through the Home Delivery Pharmacy. You can tell Us Your choice by calling Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** or by visiting Our website at **www.anthem.com.**

Your Home Delivery (Mail Order) Prescription Drug program is administered by Anthem's PBM which lets You get certain Drugs by mail if You take them on a regular basis. Your Mail Order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

> **Helpful Tip**: If You decide to use Home Delivery Choice, 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 telephone number listed on the back of Your Identification Card **(1-855-748-1804).**

The Prescription must state the dosage and Your name and address; it must be signed by Your Physician.

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. To fill any subsequent Mail Order Prescriptions for the same patient (Member), You only need to submit the Prescription and enclose Your payment.

You must authorize the Pharmacist to release information needed in connection with the filing of a Prescription to the designated Mail Order Prescription Drug Program.

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 impotence and/or sexual dysfunction, injectables, including Self-administered Injectables except insulin. Controlled substances as identified by the United States Drug Enforcement Administration are exempt from this paragraph. Please check with Customer Service by calling the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** 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 Network 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 Network Provider

You can only have Your Prescription for a Specialty Drug filled through Anthem's Specialty Network Provider. Specialty Drugs are limited to a thirty (30)-day supply per fill. The Specialty Network 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 Doctor may order Your Specialty Drug from the Specialty Network Program by calling Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804).** The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help You take charge of Your health problem and offers toll-free twenty-four (24)-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 Network 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 Network 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 Cost-Sharing Schedule. 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 Doctor may obtain a list of specialty drugs available through the Specialty Network Provider by contacting Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** or online at **www.anthem.com**. You or Your Doctor may also obtain order forms by contacting Customer Service 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 seventy-two (72) hours, or until the next business day following a holiday or weekend to allow You to get a seventy-two (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 Network 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 thirty (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 Network 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. The exception process shall begin when the clinical rationale has been received from the prescribing Provider for the exception. The decision will be made within twenty-four (24) hours. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds forty-eight (48) hours. 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 an Appeal as outlined in Section 10, “Member Satisfaction and Appeal Procedure”, of this Policy.

For a list of Drugs that need Prior Authorization, please call Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** 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-Name or Generic Drugs are covered under the Policy.

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 "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 "Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "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 "Cost-Sharing Schedule." 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 thirty (30)-day supply (fifteen (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 Our Specialty Pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow-up to monitor response to treatment and potential reactions or side-effects. You can access the list of these prescription drugs by calling the toll-free Customer Service number on the back of Your Member Identification Card **(1-855-748-1804)** 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 Customer Service

For information and assistance, You may call or write Anthem. The telephone numbers and addresses for Customer Service are listed below. Please note that the telephone numbers for Customer Service are also listed on the back of Your Identification Card.

Anthem Home Office Address

You may visit Our home office during normal business hours at:

Anthem Blue Cross and Blue Shield
1155 Elm Street
Suite 200
Manchester, New Hampshire 03101-1505

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

Customer Service Address

Or, You may write to:
Customer Service Center
Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660

VIII. Clinical Trial Costs

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 Investigative new drug application reviewed by the Food and Drug Administration.
3) Studies or investigations done for drug trials which are exempt from the Investigative new drug application.

Your 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 plan.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigative 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.

Your plan is not required to provide benefits for the following services. We reserve Our right to exclude any of the following services:

- The Investigative item, device, or service, itself; or
- items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

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

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 Policy.

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 Us, 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 Allowed Amount, including complications from the donor procedure for up to six (6) 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 a 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 first page of this Policy or on the back of Your Identification Card **(1-855-748-1804)** 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 it is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving a 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

We 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 seventy-five (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.

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

- Child care.
- Meals.
- 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, unless a minor.
- 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 Cost-Sharing Schedule for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

X. Mental Health and Substance Abuse Care

Benefits are available for Medically Necessary Mental Health and Substance Abuse Care as stated in this section. Please see Your Cost-Sharing Schedule for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information. Certain services may require Precertification. Please see the Managed Care section of this Policy for further information.

Covered Services. Benefits are available for the diagnosis, crisis intervention and treatment of acute Mental Disorders and Substance Abuse Conditions. 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.

A. Covered Services include the following:

a) 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.

b) Outpatient Services, including office visits and treatment in an outpatient department of a hospital or outpatient Facility, such as Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP).

c) Residential Treatment which is specialized twenty-four (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 Pastoral Psychotherapist;
- Licensed Professional Counselor (L.P.C.); or
- Any agency licensed by the State to give these services, when We have to cover them by law.

B. Exclusions. In addition to the Limitations and Exclusions stated in Section 7, No benefits are available for the following:

- Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy.
- Duplication of services (the same services provided by more than one therapist during the same period of time).
- Therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control except as stated in Section 6, article VI, “Surgery for Conditions Caused by Obesity.” Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity.
- Treatment of obesity or weight control programs or services.
- Custodial care, convalescent care or rest cures, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling.
- Psychoanalysis.
- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings.
- Missed appointments.
- Inpatient care extending beyond the acute detoxification phase of a Substance Abuse Condition.
- Experimental, non-traditional therapies such as crystal or aroma therapies.
- With the exception of Emergency Care, no benefits are available for services that You receive on the same day that You participate in a Partial Hospitalization Program (PHP).

XI. Maternity Care

Total maternity care includes the Providers’ fees for prenatal visits, delivery, Inpatient medical care and postpartum visits. Most often, Your Physician bills all of these fees together in one charge for delivery of a baby. The benefits for delivery of a baby include all of these services combined. Benefits are available according to the coverage in effect on the date of delivery. Note: If a Provider furnishes *only* prenatal

care or the delivery, or postpartum care, benefits are available according to the coverage in effect on the date You receive the care.

Benefits are available for routine maternity care furnished by a New Hampshire Certified Midwife (NHCM), provided that the NHCM is certified under New Hampshire law and acting within an NHCM's scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to home deliveries. Out-of-Network NHCM services are covered only if the midwife is certified under New Hampshire law.

A. Coverage is for maternity and pregnancy-related conditions.

B. Benefits for Covered Services are:

- childbirth;
- prenatal care;
- postnatal care;
- use of delivery room;
- hospital bed and board for mother and newborn;
- routine newborn nursery supplies;
- routine newborn screenings;
- routine newborn Physician services rendered in newborn nursery;
- routine circumcision of a newborn male;
- cesarean section;
- therapeutic and elective abortions;
- diagnostic laboratory and x-rays; and
- Except as stated, maternity and pregnancy-related benefits are only available to:
  - the female insured; and/or
  - the female covered spouse/domestic partner of the insured; or
  - the female Dependent child (not applicable to grandchildren).

Note: Precertification is required for all inpatient hospital services except for hospital stays for vaginal or cesarean deliveries without complications. Precertification may be required for certain diagnostic services. Precertification is always required for home visits.

Under Federal law, Anthem may not limit benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean section (C-section). However, the mother's or newborn's attending Physician, in consultation with the mother, may discharge the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours. Federal law prohibits Anthem from requiring that a Physician get Precertification before prescribing a length of stay which is not more than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a C-section.

Also, under Federal law, plans and 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.

Please see Section 7, “Limitations”, for important restrictions regarding infertility treatment.

Note: Benefits are available for complications of pregnancy.

Family planning visits, such as medical exams related to family planning and genetic counseling are covered. Outpatient/office contraceptive services are covered, provided that the services are related to the use of a FDA approved contraceptive. Examples of covered contraceptive services are: office visits, consultations examinations and services related to the use of Federal legend oral contraception or IUD insertion, diaphragm fitting, Norplant insertion or Depo-Provera injection.

XII. Vision Care Services for Members up to Age 19

We cover the following vision care services for Members to the end of the month in which they turn age nineteen (19). To receive the Network Benefit, You must use a Blue View Vision Provider. For help in finding a Blue View Vision Provider, call the number listed on the back of Your Identification Card **(1-855-748-1804).**

Routine Eye Exam

Your Policy 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. Benefits include a choice of glass or plastic lenses, factory scratch coating, standard polycarbonate and standard photochromic lenses, UV coating, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses at no additional cost when purchased from Network Providers. If You choose lens options not listed as covered in the Cost-Sharing Schedule, You will have to pay all charges for those lens options.

Covered standard eyeglass lenses include:

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

Frames

A selection of frames is covered under this plan. Members must choose a frame from the Anthem formulary.

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 only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- 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 Cost-Sharing Schedule. A selection of contact lenses is covered under this Policy. Members must choose contact lenses from the Anthem Formulary.

SPECIAL NOTE: We will not reimburse for Non-Elective Contact Lenses for any member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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.

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

Please see Section 10, "Member Satisfaction Services and Appeal Procedure", for a detailed explanation of the appeal process.

Section 7: LIMITATIONS AND 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:

for services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.

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.

that are beyond the Maximum Allowed Amount for basic and primary services, for services requested after normal Provider service hours or on holidays.

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, 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. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

for removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following Medically Necessary mastectomy.

incurred after the termination date of this coverage.

incurred prior to Your Effective Date.

for cochlear implants, except as specified in the "Covered Services" section of this Policy.

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

provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric, psychological or social 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 Policy. 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. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the Physician.

for counseling services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

for court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

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, even if psychotherapy is included.
- 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 Policy. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones 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 and 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.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

for services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

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.

that are 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 (foot pain); hyperkeratosis (callous).

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 Human Growth Hormone.

for treatment of hyperhydrosis (excessive sweating).

for care required while incarcerated in a Federal, state or local penal institution or required while in custody of Federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

for testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

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 Allowed Amounts.

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

for missed or canceled appointments.

for any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six (6) months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The plan may at its sole discretion, waive this exclusion in whole or in part for a specific new FDA Approved Drug Product or Technology.

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 Policy. This includes, but is not limited to, suture removal in an Emergency Room.

for nutritional and dietary supplements, except as provided in the "Covered Services" section of this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

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

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facility;
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- 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 (flat head syndrome);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

for physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

for stand-by charges of a Physician.

for Physician or Other Practitioners' charges for:

- 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.
- 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.

for Private Duty Nursing Services unless specifically stated in the Covered Services section.

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

for services You get from Providers that are not licensed by law to provide Covered Services, as defined in this Policy. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists).

for services which are solely performed to prevent regression of functions for an illness, injury or condition that has resolved or is stable.

for reversal of sterilization. We do not provide benefits for services to reverse voluntarily induced sterility for men or women.

for a disease or injury sustained as a result of war or participation in a riot or insurrection. No benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot or insurrection.

for 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.

for 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, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

for Smoking Cessation Programs to help You stop smoking. Please note: Preventive screenings and counseling for tobacco use are covered as required by law under the “Preventive Care” benefit. Also, Pharmacy services that help You stop smoking or reduce Your dependence on tobacco products are covered under Your Prescription Drug benefit.

for Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

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

for Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

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

for treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Policy 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 services, supplies, and equipment for the following:

- Hippotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

for weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. 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, or You have specifically opted to not receive such benefits, 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.

for ambulance, We do not provide benefits for ambulance usage when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non-Covered Services for ambulance include but are not limited to, trips to:

- A Physician's office or clinic.
- A morgue or funeral home.
- Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or Physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, Physician's office, or Your home.

for Hospice Care, We do not provide benefits for the following services, supplies or care:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

for Prescription Drugs, We do not provide benefits for the following:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the 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: 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.
- 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. This exclusion does not apply to Over-the-Counter (OTC) Drugs that We must cover under Federal law when recommended by the United States Preventive Services Task Force (USPSTF), and prescribed by a physician.
- 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 (OTC) Drugs, devices or products, are not Covered Services.
- Items Covered Under the "Allergy Services" benefit: Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit.
- 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 Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend 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.
- Drugs used for cosmetic purposes.
- Prescriptions drugs used to treat infertility.

for adult routine vision exams.

for vision care, We will not pay for services incurred for, or in connection with, any of the items below:

- Vision care for Members age nineteen (19) and older, unless covered by the medical benefits of this Policy.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- 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 which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Policy or as otherwise prohibited by Federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Policy.
- For 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 Policy.
- 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 Policy.
- Cosmetic lenses or options, unless specifically listed in this Policy.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

- No benefit is available for frames that are identified by the Provider as premium designer collections.

Section 8: CLAIMS PROCEDURES

This section explains Anthem's procedure regarding the submission and processing of claims. For the purposes of this section, **Claim Denial** means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under this Policy. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of Anthem's utilization review procedures, as well as Anthem's failure to cover a service for which benefits are otherwise provided based on Anthem's determination that the service is Experimental, Investigative or not Medically Necessary or appropriate.

Additionally, Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Services, Urgent Care Services or other services authorized by Us in accordance with this Policy, from Out-of-Network Providers, could be balance billed by the Out-of-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.

I. Post-Service Claims

Post-Service Claims means any claim for a health benefit to which the terms of the Policy do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and the health carrier.

A. Time Limit for Submitting Post-Service Claims. In order for Anthem to make payments for Post-Service Claims, Anthem must receive Your claim for benefits within twelve (12) months after You receive the service. Otherwise, benefits will be available only if:

- it was not reasonably possible to submit the claim within the twelve (12)-month period, and
- the claim is submitted as soon as reasonably possible after the twelve (12)-month period.

B. Post-Service Claim Processing. In most instances, Post-Service claims are processed as follows:

- **Network Provider or BlueCard® Provider Services.** When You receive Covered Services from a Network Provider or from a BlueCard® Provider, You will not have to fill out any claim forms. Simply identify Yourself as a Member and show Your Anthem Identification Card before You receive the care. Network Providers and BlueCard® Providers will file claims for You. You pay only the applicable Copayment, Deductible or Coinsurance amount to the Provider when You receive Your Covered Services. Eligible benefits will be paid directly to Network Providers or BlueCard® Providers.

  Claims for services furnished by a New Hampshire Provider will be processed according to the terms of New Hampshire law. If eligible for benefits, clean written claims will be processed within thirty (30) calendar days of receipt. Clean electronic claims will be paid within fifteen (15) calendar days of receipt. If We deny payment or delay processing, We will notify the New Hampshire Provider within fifteen (15) days of receipt. This notice will be mailed to the Subscriber if the Provider is a New Hampshire Out-of-Network Provider. The notice will include the reason for denial or delay and an explanation of any additional information We need to complete processing.

A “clean claim” means a claim for payment of covered health care expenses that is submitted to Anthem on Anthem’s standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with Anthem’s published filing requirements. “Electronic claims” means the transmission of data for the purpose of payment of covered health care services in an electronic data format specified by Anthem.

Any claim not paid within the time periods specified above will be deemed overdue and Anthem will include an interest payment of 1.5 percent (1.5%) per month, beginning from the date the payment was due along with the amount of the overdue claim. These requirements do not apply if: (a) Anthem’s failure to comply is caused by a directive from a court or federal or state agency; (b) Anthem is in liquidation or rehabilitation or is operating in compliance with a court-ordered plan of rehabilitation; (c) Anthem’s compliance is rendered impossible due to matters beyond Anthem’s control which are not caused by Anthem. Anthem will not be in violation for any claim submitted more than ninety (90) days after the service was rendered or while the claim is pending due to a fraud investigation that has been reported to a state or Federal agency or an Internal or External Review process.

II. Pre-Service Claims

Pre-Service Claims means any claim for a benefit under a health Policy with respect to which the terms of the Policy condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and the health carrier.

No fees for submitting a Pre-Service Claim will be assessed against You or Your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or benefit determination by submitting Your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Customer Service phone number shown on the first page of this Policy or on the back of Your Identification Card. Exception: For Urgent Care Claims, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating Physician) to be Your authorized representative without requiring Your written acknowledgment of the representation.

A. Time Limit for Submitting Pre-Service Claims. Unless it is not reasonably possible for You to do so, Pre-Service Claims must be submitted within the applicable time frames stated in this Policy. For example, You must request Precertification at least seven (7) days *before Y*ou begin a planned Inpatient admission and *within forty-eight (48) hours after* an Emergency Inpatient admission. Please see Section 4, “About Managed Care”, for information on Precertification.

B. Pre-Service Claim Processing.

Time Frames for Making Pre-Service Claim Determinations. Anthem will make a determination about Your Pre-Service Claim within the following time frames. Time frames begin when We receive Your claim and end when We make a claim determination.

- **For non-Urgent Claims,** We will make a Pre-Service Claim determination within a reasonable time period, but in no event more than fifteen (15) days after receipt of the claim, unless You or Your authorized representative fail to provide Us with the information We need to make a determination. In the case of such failure, Anthem will notify You within five (5) days after receipt of the claim.

- **For Urgent Care Claims,** We will make a Pre-Service Claim determination as soon as possible, taking into account the medical exigencies, but in no event later than seventy-two (72) hours after receipt of the claim, unless You or Your authorized representative fail to provide Us with the information We need to make a determination. In the case of such failure, Anthem will notify You within twenty-four (24) hours after receipt of the claim.
- **For Claims Relating to the Extension of an Ongoing Course of Treatment *and* Involving a Question of Medical Necessity,** We will make a Pre-Service Claim determination within twenty-four (24) hours of receipt of the claim, provided that You make the claim at least twenty-four (24) hours *before* the approved treatment period expires. If You fail to provide sufficient notice or information, We will notify You within twenty-four (24) hours after receipt of the claim. Coverage for the services will not be terminated until You are notified of Our determination.

The total time required to make a determination will not exceed the above time frames unless We find that We need more information in order to make a determination. In such cases, We will consider the claim to be incomplete and We will inform You of the specific information We need within the time frames stated above. The period of time between the date of our request for information and the date We receive the information is "carved out" of (does not count against) the above stated time frames.

C. Notice of a Claim Denial. Our notice of a Pre-Service Claim Denial will be in writing or by electronic means and will include the following:

- The specific reason(s) for the determination, including the specific provision of this Policy on which the determination is based.
- A statement of Your right to access the internal Appeal Process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, We will include a description of the expedited review process.
- The name and credentials of Anthem's Medical Director, including board status and the state or states where the Medical Director is currently licensed. If the person making the Claim Denial is not the Medical Director but a designee, We will include the designee's credentials, board status, and state or states of current license.
- The relevant clinical rationale used to make the Claim Denial.
- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Claim Denial, We will reference the guideline in Our notice. We will either include a copy of the guideline with Our notice or We will inform You that a copy is available to You free of charge upon request.
- If clinical review criteria were relied upon in making the Claim Denial, We will inform You and Your treating Provider about the criteria. Our notice will be accompanied by the following statement: "The materials provided to You are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under the Member's Policy."

- If a Claim Denial is based on a Medical Necessity or experimental treatment or other similar exclusion or limit, We will include an explanation of the scientific or clinical judgment for the determination, applying the terms of this Policy to Your medical circumstances.

Anthem will not release proprietary information protected by third party contracts.

III. Appeals

Please see Section 10, “Member Satisfaction Services and Appeal Procedure”, for complete information about the Appeal Procedure.

IV. General Claims Processing Information

Claim Forms. Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claim form to Us, or contact Customer Service at the telephone number listed on the back of Your Identification Card **(1-855-748-1804)** and ask for a claim form to be sent to You. Claim forms will be furnished to You if needed within fifteen (15) days after this written notice. If You do not receive the claim form, 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 Provider’s signature.

Network Provider Services. When You receive Covered Services from a Network Provider, You will not have to fill out any claim forms. Simply identify Yourself as a Member and show Your Anthem Identification Card before You receive the care. Network Providers will file claims for You. You pay only the applicable Copayment, Deductible or Coinsurance amount to the Provider when You receive Your Covered Services, Eligible benefits will be paid directly to Network Providers.

Anthem reserves the right to pay either You or the hospital or any other Provider. You cannot assign any benefit monies due under this Policy to any person, Provider, corporation, organization or other entity. Any assignment by You will be void and have no effect. Assignment means the transfer to another person, Provider, corporation, organization or other entity of Your right to the benefits available under this Policy.

A. Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two (2) or more family members' Maximum Allowed Amounts for Covered Services combine to equal the family Deductible, then no other individual Deductible needs to be met for that Calendar Year. No one (1) person can contribute more than his/her individual Deductible to the family Deductible.

The Deductible applies to most Covered Services even those with a zero percent (0%) 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 Policy works, please refer to the Cost-Sharing Schedule.

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

B. 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 (2) 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 (1) person can contribute more than their individual Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost-Share will be required for the remainder of the Calendar Year.

V. Inter-Plan Arrangements

Out-of-Area Services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard® Program, when You obtain out-of-area Covered Services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating Providers; and (b) handling interactions with those Providers.

The BlueCard® Program allows You to obtain out-of-area Covered Services and supplies from a healthcare Provider participating with a Host Blue, where available. The participating Provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment, Coinsurance and/or Deductible stated in this Policy.

Whenever You obtain Covered Services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard® Program, the amount You pay for them, if not a Copayment, 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 special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for Your claim or Your liability for any such claim.

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 laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate Your liability for any Covered Service or supply according to applicable law.

Out-of-Network Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of-Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If You need to go to an Out-of-Network, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of Out-of-Network, out-of-area Providers are covered, the amount that You pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from Out-of-Network Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where You did not have reasonable access to a Network Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying an Out-of-Network Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

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 Identification 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 twenty-four (24) hours a day, seven (7) days a week. The toll free number is **1-800-810-2583**. Or You can call them collect at **1-804-673-1177**. 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 Precertification. 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 Section 4 "Managed Care", under article III "Requesting Approval for Benefits", to learn how to get Precertification when You need to be admitted to the hospital for 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.

Section 9: OTHER PARTY LIABILITY AND RECOVERY RIGHTS

The following guidelines apply to all claims for benefits under Your Policy:

I. Other Health Coverage

You are not eligible to enroll under this Policy if You have other health coverage. If You do not disclose other coverage on Your enrollment form, the rules in Section 12, "Membership Eligibility, Termination of Coverage and Continuation of Coverage", of Your Policy will apply. Please see "Statements and Forms", in Section 12. Failure to notify Anthem about eligibility for other coverage does not alter the terms of Your Policy and does not void Anthem's recovery rights.

Please Note: If You become eligible for Medicare, You should contact Your local Social Security Office right away. You may remain enrolled in this plan after You become Medicare eligible. However, You must inform Anthem immediately about Medicare eligibility. You may want to call Anthem's toll-free Customer Service phone number on the first page of this Policy or on the back of Your Identification Card **(1-855-748-1804)** to ask about Anthem's Medicare supplement plans.

II. Workers' Compensation

This plan does not cover any care, condition, disease or injury that arises out of or in the course of employment when You are covered by Workers' Compensation. This exclusion does not apply if You or Your employer waived coverage in accordance with New Hampshire law.

III. Subrogation and Reimbursement

In this section, "Recovery" means: money You receive from a source other than Anthem as a result of an injury, illness, impairment or medical condition caused by another, but not with respect to medical or liability insurance offered under either a general liability insurance or an auto insurance policy. Regardless of how a Recovery agreement is represented, it will be subject to the terms of this section.

A. Subrogation. If You suffer an injury, illness, impairment or medical condition as the result of another party's actions, and Anthem pays benefits to treat the injury, illness, impairment or medical condition, Anthem will be subrogated to Your Recovery rights. Anthem may proceed in Your name against the responsible party. Additionally, Anthem has the right to recover payments made on Your behalf from any party responsible for compensating You. All of the following apply except to the extent limited by law:

- Anthem may pursue from any Recovery its subrogation rights for the full amount of benefits Anthem has paid. This rule applies regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses.
- You and Your representatives must do whatever is necessary to enable Anthem to exercise the rights set forth in this Policy and do nothing to prejudice Anthem's rights.
- Anthem has the right to take whatever legal action is seen fit against any party or entity to recover benefits paid under this plan.
- To the extent that the total assets available from a Recovery are insufficient to satisfy in full Anthem's subrogation claim and any claim still held by You, Anthem's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- Anthem is not responsible for any attorney fees, other expenses or costs You incur without the prior written consent of Anthem.

Nothing in this Policy shall be construed to limit Anthem's right to utilize any remedy provided by law to enforce its subrogation rights. If You are injured or suffer an impairment or medical condition that is the result of another party's actions, and Anthem pays benefits for Your treatment, Anthem will be subrogated to Your recovery rights. Anthem is entitled to reimbursement from the responsible party or any other party that provides payment to You, to the extent of benefits provided. Anthem's subrogation right includes, but is not limited to: underinsured or uninsured motorists' coverage. By accepting Your Policy, You agree to cooperate with Anthem and do whatever is necessary to secure Anthem's right and do nothing to prejudice Anthem's rights. Anthem reserves the right to compromise on the amount of the claim if Anthem determines that it is appropriate to do so. Any action that interferes with Anthem's subrogation rights may result in the termination of coverage for the Subscriber and covered Dependents.

B. Reimbursement. If You obtain a Recovery, Anthem has a right to be repaid from the Recovery up to the amount paid by Anthem on Your behalf.

IV. Recovery of Incorrect Payments or Overpayments

Anthem has the right to recover incorrect payments or overpayments from any Member, person or entity. Anthem will notify any Member subject to a recovery action. The Member must remit the required amount to Anthem or provide Anthem with written notice of the reasons the Member may be entitled to the payment. The Member's written notice or the recovery amount must be submitted to Anthem within sixty (60) days of Anthem's recovery notice. If repayment is a financial hardship to a Member, the Member should ask about Anthem's interest free installment plan. Anthem's mailing address and toll-free telephone number **(1-855-748-1804)** appear on the recovery notice.

Anthem has the right to:

- Take any action needed to carry out the terms of this Policy.
- Exchange information with Your other insurance company or other party.
- Recover Anthem's excess payment from another party or reimburse another party for its excess payment; and
- take these actions when Anthem decides they are necessary without notifying the Member.

When another entity pays benefits that should have been paid by Anthem, Anthem has the right to pay the other entity any amount that Anthem determines to be warranted to satisfy the intent of this Policy. Amounts paid are benefits under Your Policy and to the extent of such benefit payments, Anthem is fully discharged from liability under Your Policy.

This provision does not permit dissemination of information to those without legitimate interest in the information. This provision does not permit in any manner the dissemination of information prohibited by law.

V. Your Agreement and Responsibility Under This Policy

By accepting Your Policy, You agree to cooperate with Anthem to effect the terms of this Policy. You agree to provide prompt, accurate and complete information to Anthem about other health coverage and/or insurance policies or benefits You have. You agree to provide information about other

coverage when necessary to carry out the terms of this Policy. Other health coverage, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Worker's Compensation and/or claims against liability or casualty insurance companies arising from an injury, illness, impairment or medical condition You receive, subject to limitations noted in RSA 415:6, II (4). By accepting this Policy You must:

- Promptly notify Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition occurred and all information regarding the parties involved.
- Cooperate with Anthem in the investigation, settlement and protection of rights.
- Not do anything to prejudice Anthem's rights.
- Send to Anthem copies of police reports, notices of other papers received in connection with Your accident or incident; and/or
- promptly notify Anthem if You retain an attorney or if a lawsuit is filed on Your behalf. Any action that interferes with Anthem's rights under this Policy may result in coverage termination for the Subscriber and Dependents covered under the Subscriber's Policy.

Section 10: MEMBER SATISFACTION SERVICES AND APPEAL PROCEDURE

Please see Section 13 for definitions of specially capitalized words.

This section explains how to contact Anthem when You have questions, suggestions, concerns or complaints.

I. Member Satisfaction Services

Anthem provides quality member satisfaction services through Our Customer Service Centers. All Anthem personnel are responsible for addressing Your concerns in a manner that is accurate, courteous, respectful and prompt. Customer Service Representatives are available to:

- answer questions You have about Your membership, Your benefits, Covered Services, Network Providers, the plan's Provider Network, payment of claims, and about policies and procedures,
- provide information or plan materials that You want or need (such as health promotion brochures, the Provider Directory, or replacement of Identification Cards),
- make sure Your suggestions are brought to the attention of the appropriate persons,
- to assist You should You have a complaint, problem or question about Your Policy or any service received, You may contact Customer Service at **1-855-748-1804**,
- provide assistance to You (or Your authorized representative) when You want to file an internal appeal.

Your identification number helps to locate Your important records with the least amount of inconvenience to You. Your identification number is on Your Identification Card. Please be sure to include Your entire identification number (with the three (3)-letter prefix) when You call or write.

If You have a concern about the quality of care offered to You by a participating or Network Provider (such as waiting times, Physician behavior or demeanor, adequacy of facilities or other similar concerns), You are encouraged to discuss the concerns directly with the Provider before You contact a Customer Service Representative.

Anthem will respond to most of Your questions or requests at the time of Your call or within a few days. Please see article II, "Internal Appeal Procedure" (below), for complete information about the internal appeal procedure. You may have the right to an independent External Review, as summarized under article III, "External Review" (below).

Please contact **Anthem's Customer Service Center** about Your membership, benefits, Covered Services, complaints, plan materials and Participating or Network Providers. Anthem's toll-free telephone number **(1-855-748-1804)** is also on first page of this Policy and on Your Identification Card.	Or, You may write to: Customer Service Center Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, CT 06473-0660

You may choose to contact the **State of New Hampshire Insurance Department** for assistance at any time during business hours. Call the Insurance Department at: **1-800-852-3416**	Or, You may write to: Life, Accident and Health Consumer Affairs Coordinator State of New Hampshire Insurance Department 21 South Fruit Street, Suite 14 Concord, NH 03301

For more information about Member services, please visit Anthem's Web site at www.anthem.com.

II. Internal Appeal Procedure

You have the right to receive benefits for Covered Services, as described in Your Policy. You may appeal any Claim Denial made by Anthem. This section explains the internal appeal procedure. Please see article IV, "Definitions" below, for the definitions of "Claim Denial", "Post-Service Claim", "Pre-Service Claim" and "Urgent Care Claim."

Please refer to Section 6 article VII, "Prescription Drugs"; the item titled "Prescription Drug List", for the process for submitting an exception request for Drugs not on the Prescription Drug List.

Anthem conducts and oversees internal appeals. No fees for submitting an appeal will be assessed against You or Your authorized representative. Please note that oral statements by agents or representatives of Anthem do not change the benefits described in Your Policy.

The internal appeal procedure provides for a full and fair review, as required by New Hampshire law. For example:

- The person(s) reviewing Your appeal will not be the same person(s) who made the initial Claim Denial or a subordinate or supervisor of the person(s) who made the initial Claim Denial,
- The person(s) reviewing Your appeal will have appropriate medical and professional expertise and credentials to competently render a determination on appeal,
- You have one hundred-eighty (180) days to file an appeal, following receipt of Anthem's Claim Denial notification,
- You may submit written comments, documents, records, and other information relating to Your appeal, without regard to whether those documents or materials were considered in making the initial Claim Denial,
- You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to or considered in making the initial Claim Denial,
- Your issue will be considered as new (de novo), as if the issue had not been reviewed before and as if no decision had been previously rendered. All information, documents, and other material submitted for the internal appeal procedure will be considered without regard to whether the information was considered in making a Claim Denial,

- If Your appeal of a Claim Denial is based in whole or in part on a medical judgment, reviews will be conducted by or in consultation with a health care professional who has appropriate training and experience in the field of medicine. Appeal determination notices will provide the titles and qualifying credentials of the person conducting the review. At Your request, the identity and qualifications of any medical or vocational expert whose advice was considered in making the initial Claim Denial (without regard to whether it was relied upon) will be provided.

Please Note: In addition to the internal appeal procedure described below, You may have the right to an External Review arranged through and overseen by the New Hampshire Insurance Department. For complete information about rights and restrictions, please see article III, "External Review" (below, and the Managed Care Consumer Guide to External Appeal (enclosed with Your Policy).

Who may submit an internal appeal? You or Your authorized representative may submit an internal appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Member Service phone number on the first page of this Policy or on the back of Your Identification Card. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating physician) to be Your authorized representative without requiring Your written acknowledgement of the representation, or

- a court order is in effect authorizing the person to act on Your behalf and a copy of the order is on file with Anthem.

What should be included with an internal appeal? Please include Your identification number (including the three (3)-letter prefix) and describe the services that You are submitting for review. If possible, refer to the date You received the service and state the name of the Doctor, hospital or other Provider that furnished the care. You may also want to include:

- bills that You have received from the provider, and

- any information that You believe is important for review, such as statements from Your Physician or letters You received from Anthem.

- You may point out the portion of Your Policy that You believe pertains to Your appeal. You should state the outcome You are expecting as a result of Your appeal.

Anthem may ask You to sign an authorization so that medical records can be obtained to conduct the appeal.

Internal Appeal Process. You may call or write to initiate an internal appeal. Letters should be addressed to:

Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 518
North Haven, CT 06473-0518

As an alternative, You may submit an internal appeal through Anthem's website**, www.anthem.com**. Your appeal must be submitted within at least one hundred-eighty (180) days of Anthem notification about the issue that caused You to appeal.

By accepting Your Policy, You agree that the internal appeal procedure provides that one mandatory level of internal appeal is available to You. Your obligation to follow the mandatory appeal procedure is fulfilled when:

- The internal appeal is completed, or
- You seek External Review of an Adverse Determination before the internal appeal is complete, in keeping with the terms of article III, "External Review" below.

Time Frames for Appeal Determinations. Anthem will complete the internal appeal process within the following time frames, unless You and Anthem mutually agree to extend the time frames. Time frames begin when Your appeal is received (whether or not all of the necessary information is contained in the filing) and end when notice of the claim determination is issued to You.

Expedited Appeals. An expedited appeal procedure is available for Urgent Care Claim Denials, or Claim Denials concerning an admission, availability of care, continued stay or health care service for Members who have received emergency services, but who have not been discharged from a facility. You may submit information to support Your appeal by telephone, facsimile or other expeditious method.

Anthem will make a decision and notify You as expeditiously as Your medical condition requires, but in no event more than seventy-two (72) hours. If an initial notice of the determination is not in writing, a written confirmation of Anthem's decision will be provided to You within two (2) business days.

If You or Your authorized representative fail to provide the information needed to make a determination, Anthem will notify You within twenty-four (24)-hours after receipt of Your appeal.

Ongoing Urgent Care services will be continued as directed by Your Physician without liability to You until You are notified. You will be held harmless for the cost of care under review, pending the outcome of the internal appeal procedure. This provision applies only to services that are stated as Covered Services in Your Policy. This provision does not waive Your cost sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in Your Policy. If the internal appeal procedure results are adverse to You, You may be responsible for paying the cost of non-covered services, according to the terms and conditions of your Policy. Expedited Appeals are not available for Post-Service Claims.

Non-expedited Pre-Service Claim Appeals. Anthem will make a decision and notify You within a reasonable time appropriate to Your medical circumstances, but in no event more than thirty (30) days.

Post-Service Claim Appeals. Anthem will make a decision and notify You within a reasonable time appropriate to Your medical circumstances, but in no event more than thirty (30) days.

Please Note: You may be eligible for an independent External Review overseen by the New Hampshire Insurance Department before completing the internal appeal process. Please see article III, "External Review" (below) for more information.

Content of Notice of an Appeal Determination. Anthem's notice of an appeal determination will include the following:

- The specific reason or reasons for the determination. You will be informed about any guideline (such as a policy provision, internal rule or protocol or other similar criteria) that was relied upon in making the determination. A copy of the guideline will be provided, or You will be informed that a copy is available free of charge at Your request,
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits, (the records on file with Anthem may be limited in scope. Please

contact Your Physician if You have questions or concerns about the content of Your medical records),

- A statement describing all other dispute resolution options available to You, including but not limited to Your options for external review or for bringing a legal action,

- If the Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, You will receive an explanation of the scientific or clinical judgment for the denial, applying the terms of Your Policy to Your medical circumstances, or You will be informed that such explanation will be provided free of charge at Your request.

- Appeal determination notices will remind You that You have the right to contact the Insurance Commissioner's office for assistance. The Insurance Commissioner's address and toll-free telephone number will be included in Anthem's notice.

III. External Review

External Review through the New Hampshire Insurance Department. You may have the right to an independent External Review of an **Adverse Determination.** "Adverse Determination" means a decision by Anthem (or by a designated clinical review entity of Anthem's), that a scheduled or emergency admission, continued stay, availability of care, or other admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, benefits are denied, reduced or terminated by Anthem.

External Reviews are arranged through and overseen by the New Hampshire Insurance Department. They are conducted by neutral Independent Review Organizations (IRO) as certified by the Insurance Department. Anthem pays for the cost of IRO services. There is no cost to You for External Review. For complete information (including instructions on how to submit new information for review and time frames for completing an External Review), please see the Insurance Department's Managed Care Consumer Guide to External Appeal, enclosed with Your Policy. Please note that the Insurance Department offers oversight of standard and expedited External Reviews.

IMPORTANT NOTE: In accordance with the provisions of RSA 420-J:5-a, II(a), Premium Assistance Program (PAP) plans provided under Medicaid, are subject to the External Review provisions shown in this section of Your Policy.

Your decision to seek External Review is a voluntary level of appeal. It is not an additional step that You must take in order to fulfill Your internal appeal procedure obligations, as described in article II, "Internal Appeal Procedure" above.

A. Eligibility. As described in the Managed Care Consumer Guide to External Appeal, You are eligible for independent External Review, provided that the topic of the review is an ***Adverse Determination*** made by Anthem and:

- the service under appeal is a Covered Service and is not subject to an exclusion or annual maximum, as stated in Your Policy. Or, the service would be covered if certain clinical conditions were met and the decision about coverage is therefore an Adverse Determination. (For example, Anthem may determine that service is Experimental, Investigative or cosmetic and You disagree that the service is Experimental, Investigative or cosmetic. Another example is: Anthem may deny coverage for care outside the network because Anthem finds that appropriate care can be provided in the network and You disagree with the finding), and

- Your review request is not for the purpose of pursuing a claim or allegations of health care provider malpractice, professional negligence or other professional fault, and
- You have completed the internal appeal procedure stated in article II, "Internal Appeal Procedure" (above), and the final decision is adverse, or
- the time frames stated for completion of the internal appeal procedure are not met, or
- You and Anthem agree to submit the appeal for External Review before the internal appeal procedure is completed.

B. Notice. Anthem will provide complete notice of Your rights to an External Review whenever:

- an internal appeal procedure is completed and the final decision is an Adverse Determination, or
- the time frame for completion of an internal Adverse Determination appeal is not met (Our notification will be issued on the day that the time frame expires), or
- You and Anthem agree to waive the internal appeal procedure in order to seek External Review.

In addition to other notification requirements stated in article II, "Internal Appeal Procedure" (above), External Review notices will include the Managed Care Consumer Guide to External Appeal, which contains complete information about the rights, responsibilities, restrictions and time frames.

Please Note: The Insurance Department's Request for Independent External Appeal of a Health Care Decision is a form which You must complete and submit to the Insurance Department to initiate an External Review. For expedited External Review, You must submit the Insurance Department's Certification of Treating Health Care Provider For Expedited Consideration of a Patient's External Appeal. These forms are found at the end of the consumer guide.

You must submit Your *Request for Independent External Appeal of a Health Care Decision* to the New Hampshire Insurance Department no later than one hundred-eighty (180) days after the date of Anthem's notice. Please contact the Insurance Department if You need assistance with the request forms. The telephone number and address are shown in article I, "Member Satisfaction Services" (above).

C. The Insurance Department's Guide to External Review Rights. You are encouraged to read the New Hampshire Insurance Department's Managed Care Consumer Guide to External Appeal, which is enclosed with Your Policy. The guide contains important information regarding the External Review process and time frames. It explains Your rights and responsibilities and those of the Insurance Department, its certified Independent Review Organizations and Anthem.

Please Note: Anthem will forward to You and the IRO all the information in Anthem's possession that is relevant to Your appeal within ten (10) days of receiving notice from the Insurance Department that Your request for External Review is accepted. The information may include medical records, as required by law. The records on file with Anthem may be limited in scope. Please contact Your Physician if You have questions or concerns about the content of Your medical records. The Insurance Department and IRO will not disclose

protected health information or other internal materials prepared for specific External Reviews.

When handling a review on an expedited basis, the selected IRO will make a decision and notify Anthem and You as expeditiously as Your medical condition requires, but in no event more than seventy-two (72) hours after the expedited external review is requested. If the initial notice was not in writing, written confirmation of the decision will be made to You or Your authorized representative and to Anthem within two (2) business days of the non-written notice. The written notice will state whether Anthem's determination is upheld or reversed. The written notice will also include a statement of the nature of Your grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

If an expedited External Review is conducted during Your hospital stay or while You are continuing a course of treatment, Your stay or treatment will continue, as directed by Your Physician. You will be held harmless for the cost of the care under review, pending the determination of the IRO. This provision does not waive Your cost sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in Your Policy. If the external review results are adverse to You, You may be responsible for paying the cost of non-covered services, according to the terms and conditions of Your Policy.

If You submit new information to the Insurance Department during the External Review process which Anthem has not reviewed, Anthem may, after reviewing the new information, reverse Your adverse determination and approve coverage. This reconsideration of Your adverse determination may terminate Your External Review request.

If the original decision is reversed due to review of new information, Anthem will approve coverage and notify You, the Insurance Department and the IRO. In all other circumstances, the IRO will notify You, the Insurance Department and Anthem of the External Review outcome. Standard notice will be made in writing within twenty (20) days of the date that the case record is closed. For expedited reviews, notice will most often be made immediately by telephone or fax, followed by written notice.

An Independent Review Organization's External Review decision is binding on Anthem. It is also binding on You, except to the extent that You have other remedies available under Federal or state law.

IV. Definitions

Claim Denial means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under the Policy. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of Anthem's utilization review procedures, as well as Anthem's failure to cover a service for which benefits are otherwise provided based on Anthem's determination that the service is Experimental, Investigative or not Medically Necessary or appropriate.

Post-Service Claims are claims for services that You have received and which do not meet the definition of "Pre-Service Claim" stated below in this subsection. Post service claim means any claim for a health benefit to which the terms of the Policy do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-service claim"

shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and the health carrier.

Pre-Service Claim. Certain services are covered in part or in whole if You request and obtain Precertification or preauthorization *in advance* from Anthem. Requests for Precertification and preauthorization, submitted as required under Your Policy, are Pre-Service Claims. Pre-Service Claims do not include requests for reimbursement made by Providers according to the terms of their agreements with Anthem.

Urgent Care Claim means any claim for medical care or treatment that if not treated within forty-eight (48) hours presents a risk of serious harm with respect to making non-urgent Pre-Service Claim determinations:

- could seriously jeopardize Your health or Your ability to regain maximum function, or
- 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 proposed care or treatment.

V. Disagreement with Recommended Treatment

Your Physician is responsible for determining the health care services that are appropriate for You. You may disagree with Your Physician's decisions and You may decide not to comply with the treatment that is recommended by Your Physician. You may also request services that Your Physician feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, You have the right to refuse the recommendations of Your Physician. In all cases, Anthem has the right to deny care that is not a Covered Service or is not Medically Necessary as defined in Your Policy or is otherwise not covered under the terms of Your Policy.

Section 11: GENERAL PROVISIONS

Our Responsibility to Notify You About Changes. If We change the provisions of this Policy, You will be given reasonable notice before the Effective Date of the change. We will provide You with at least sixty (60) days prior notice in the event of any Premium rate increase. No change in this Policy shall be valid until approved by an executive officer of Anthem and unless such approval is endorsed or attached to the Policy. Any notice which Anthem gives to You will be in writing and mailed to You at the address as it appears on Our records.

Right to Change the Policy. No agent has the right to change or waive any of the provisions of this Policy. No change in this Policy shall be valid until approved by an executive officer of Anthem and unless such approval is endorsed or attached to the Policy.

Premiums. The Premium rates are guaranteed for the twelve (12) month period following the first day of the Calendar Year. The Premium for this Policy may change subject to, and as permitted by, applicable law. You will be notified of a proposed Premium change at the address in Our records sixty (60) 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.

Any significant misrepresentation or omission may cause Anthem to change Your Premium retroactive to the Effective Date of coverage. If the age of the Subscriber has been misstated, all amounts payable under this Policy shall be such as the Premium paid would have been if purchased at the correct age.

Non-Sufficient Funds. 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.

Waiver. Neither the waiver by Anthem of a breach of or a default under any of the provisions of this Policy, nor the failure of Anthem, on one or more occasions, to enforce any of the provisions of this Policy or to exercise any right or privilege under this Policy, will be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any provisions, rights or privileges.

Applicable Law. This Policy, the rights and obligations of Anthem and Members under this Policy, and any claims or disputes relating to this Policy, will be governed by and construed in accordance with the laws of the State of New Hampshire. This Policy is intended for sale in the State of New Hampshire. Your Policy is intended at all times to be consistent with New Hampshire law. If New Hampshire laws, regulations or rules require Anthem to provide benefits that are not expressly described in this Policy, then this Policy is automatically amended only to the extent specified by the laws, regulations or rules that are enacted by the State of New Hampshire.

Anthem is not Responsible for Acts of Providers. Anthem is not liable for the acts or omissions by any individuals or institutions furnishing care or services to You.

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 In-Network Providers, Out-of-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Us.

Member Privacy. Anthem Blue Cross and Blue Shield's practices regarding the protection of personal health information are stated in Our Notice of Privacy Practices. Our Notice of Privacy Practices is included with Your Policy.

Right to Develop Guidelines. Anthem reserves the right to develop or adopt criteria which set forth in more detail the instances and procedures when payments of benefits will be made under this Policy. Examples of the use of the criteria are to determine whether care was Medically Necessary, whether emergency care was Medically Necessary, or whether certain services are skilled care or are cosmetic or Experimental. These criteria will be interpretive and illustrative only and will not be contrary to any term or provision of this Policy. If You have a question about the criteria which apply to a particular benefit, You may contact Anthem for further information.

Limitation on Benefits of This Policy. No person or entity other than Anthem and Members are entitled to bring any action to enforce any provision of this Policy against Anthem or Members and the provisions of this Policy will be solely for the benefit of, and enforceable only by, Anthem and the Members covered under this Policy.

Acknowledgment of Understanding. By accepting this Policy, You expressly acknowledge Your understanding that this Policy constitutes a benefit plan provided by Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The license permits Anthem to use the Blue Cross and Blue Shield service marks in the State of New Hampshire. The Plan is not contracting as an agent of the Blue Cross and Blue Shield Association. You also acknowledge that You have not accepted this Policy based upon representations by any person other than Anthem, and that no person, entity or organization other than Anthem will be held accountable or liable to You for any of Anthem's obligations created under this Policy. These acknowledgments in no way create any additional obligations whatsoever on the part of Anthem other than those set forth in this Policy.

Section 12: MEMBERSHIP ELIGIBILITY, TERMINATION OF COVERAGE AND CONTINUATION OF COVERAGE

I. Eligibility

The benefits, terms and conditions of this Policy 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 Policy, 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, 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 New Hampshire; and meet the following applicable residency standards;

For a Qualified Individual age twenty-one (21) and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent; and
- Reside in the Service Area of the Exchange.

For a Qualified Individual under age twenty-one (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; 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 twenty-one (21), the service area is that of the parent or caretaker with whom the Qualified Individual resides or the service area of the Exchange in which he or she 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.
   - For purposes of this Policy, 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.
   - 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.
   - 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 who are under age twenty-six (26).
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who is under age twenty-six (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 sixty (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 Policy.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Policy 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 sixty (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. There are four metal levels of coverage that may be offered (Bronze, Silver Gold and Platinum). Gold and Silver are required to be offered by QHP insurers that are participating on the Exchange. Metal levels vary depending on benefits, Premium, Deductibles, Copayments and Coinsurance. Your Premium and coverage increase with each level.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber, the Subscriber's spouse, or the Subscriber's Dependent will be covered for an initial period of thirty-one (31) days from the date of birth. Newborn Children of the Subscriber or the Subscribers spouse will continue beyond the thirty-one (31) days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Policy. The form must be submitted along with the additional Premium, if applicable, within sixty (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 Award of 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 Policy must be submitted to the Exchange within sixty (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 Policy, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Policy, and once approved by the Exchange We will provide the benefits of this Policy 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 Policy 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 thirty (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 or Subscriber;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:

    - Individual who no longer resides, lives or works in Anthem'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, and
    - Exhaustion of COBRA benefits.

Effective date for 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 Policy. The Exchange must be notified of any changes as soon as possible but no later than within sixty (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 sixty (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 Policy 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 a Policy for each Subscriber.

II. 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, moves 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, and the grace period has been exhausted.
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 either:

1) The three (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 three (3)-month grace period; or
2) any other 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:
   - The termination date specified by the Member, if reasonable notice is provided;
   - Fourteen (14) days after the termination is requested, if the Member does not provide reasonable notice; or
   - 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 (14) 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, except when a Member turns age twenty-six (26), the Member remains on the Policy until the end of the Plan Year, or if the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the three (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 three (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, consistent with existing State laws regarding grace periods.
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 Policy, 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 Policy is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable state and Federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Policy annually 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 Policy; and
3) This Policy 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 Policy, 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 Policy 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 thirty-one (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 thirty (30) days written notice prior to rescission of this Policy.

This Policy 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 Policy. Termination will be effective thirty-one (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.

III. Discontinuation of Coverage

We can refuse to renew Your Policy 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 ninety (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. Non-renewal will not affect an existing claim.

Grace Period

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

If the Subscriber does not pay the required Premium by the end of the grace period, the Policy is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Year, We must provide a grace period of at least three (3) 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 three (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 Policy as provided herein. 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 three (3)-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Policy has a grace period of thirty-one (31) days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Policy will stay in force and claims will be pended unless prior to the date Premium payment is due, You give timely written notice to Us that the Policy is to be terminated. If You do not make the full Premium payment during the grace period, the Policy will be terminated on the last date through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last date through which Premium is paid.

After Termination

Once this Policy 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 Policy. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Section 13: 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) 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.

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.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc. Anthem is a stock corporation licensed in the State of New Hampshire. Matthew Thornton Health Plan underwrites this plan and Anthem administers this plan. The terms We, Us and Our in this Policy refer to Anthem and its designated affiliates.

Balance Billing means when a Provider bills You for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is $100 and the allowed amount is $70, the Provider may bill You for the remaining $30. A Network Provider may not balance bill You for Covered Services.

Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

BlueCard® Provider means a Provider located *outside New Hampshire* that has a standard written payment agreement with the Local Plan. BlueCard® Providers who do not have a written payment agreement with the Local Plan are not Network Providers.

Brand-Name Drugs means Prescription Drugs that the Pharmacy Benefits Manager (PBM) has classified as Brand-Name Drugs through use of an independent proprietary industry database.

Care or Medical Expense includes, but is not limited to, health services such as: diagnosis, medication, office visits, tests, injections, therapies, hospitalization and use of medical equipment, supplies or devices.

Claim Denial means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under this Policy. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of Our utilization review procedures, as well as Our failure to cover a service for which benefits

are otherwise provided based on Our determination that the service is Experimental, Investigative or not Medically Necessary or appropriate.

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.

Contracting Provider means a Provider that has an agreement with Anthem to provide certain Covered Services to Members. A Contracting Provider is not a Network Provider.

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 Service means services for which coverage is available under this Policy.

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, or are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, but are not limited to, abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Durable Medical Equipment (DME) means the equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics**.**

Effective Date means the date Your coverage begins under this Policy. Coverage will take effect as of 12:01 a.m. on Your Effective Date.

Experimental/Investigative means a Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration (FDA) at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing Phase I, II, III or IV clinical trial 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 substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

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-Name 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 means prescription drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database and that the FDA has determined meet bioequivalency standards and therefore are therapeutically equivalent. 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.

Habilitative/Habilitation Services means health care services that help You keep, learn, or improve skills and functioning for daily living. 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 Agency means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

Hospice Care means 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 twenty-four (24) hours a day, seven (7) days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Inpatient means a Member who receives care as a registered bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility, where a room and board charge is made. It does not mean a Member is placed under observation for less than twenty-four (24) hours.

Local Plan means the Blue Cross and Blue Shield Plan in the geographic area where You receive Covered Services (outside the Service Area). The Local Plan has Provider payment agreements with local Network Providers. The Local Plan has standard payment agreements with BlueCard® Providers.

Maintenance Medications means Prescription Drugs 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 listed on the first page of this Policy or on the back of Your Identification Card or check Our website at **www.anthem.com** for more details.

Maximum Allowed (Allowable) Amount (MAA) means reimbursement for services rendered by Network and Out-of-Network Providers is based on the Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-Plan Arrangements" section of this Policy for additional information.

The Maximum Allowed Amount 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 benefit program 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 Policy.

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 an Out-of-Network 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.

Generally, services received from an Out-of-Network Provider under this Policy are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us.

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 Network Provider or an Out-of-Network Provider.

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

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

For Covered Services You receive from an Out-of-Network Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Policy will be one of the following as determined by Anthem:

1) An amount based on Our Out-of-Network 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, 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 Out-of-Network Provider.

Providers who are not contracted for this health benefit plan, but contracted for other Anthem health benefit plans are also considered Out-of-Network. For this Policy the Maximum Allowed Amount reimbursed for services from these Providers will be one of the five (5) methods shown above unless the contract between Anthem and that Provider specifies a different amount.

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

Customer Service is also available to assist You in determining this Policy's Maximum Allowed Amount for a particular service from an Out-of-Network 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 Your Out-of-Pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

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

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Policy, 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-Share amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider Facility and receive Covered Services from an Out-of-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.

AUTHORIZED SERVICES

In some non-Emergency circumstances, such as where there is no Network Provider available for the Covered Service, 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 an Out-of-Network Provider. In such circumstance, You must contact Anthem in advance of obtaining the Covered Service.

We also will authorize the Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency services from a 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 an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

- **Example:**

  You require the services of a specialty Provider; but there is no Network Provider for that specialty in Your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Out-of-Network Provider for that Covered Service and We agree that the Cost-Share will apply.

  Your Policy has a $25 Copayment for Network Providers for the Covered Service. The Out-of-Network Provider's charge is $500. The Maximum Allowed Amount is $200.

  Because We have authorized the Network Cost-Share amount to apply to this situation, You will be responsible for the Network Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

  Because the Out-of-Network Provider's charge for this service is $500, You may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Network Copayment of $25, Your total Out-of-Pocket expense would be $325.

Medical Director means a physician licensed under NH law, employed by Anthem who is responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medically Necessary or "Medical Necessity" means health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

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

Please Note: The fact that a Network Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or

independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product, prescribed for a Member.

You have the right to appeal benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding medical necessity. Please refer to the appeal process in Section 10, "Member Satisfaction Services and Appeal Procedure", of this Policy for complete information.

Please review plan rules stated in Sections 1 through 5 in this Policy. Benefits may be reduced if You fail to follow plan rules, whether or not Your service meets Anthem's definition of "Medically Necessary". Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Network Providers and requirements about Precertification from Anthem.

Member means a Subscriber and any spouse of a Subscriber or domestic partner, or dependents of the Subscriber or of the Subscriber's spouse or domestic partner who has satisfied the eligibility conditions, applied for coverage, has been approved by Us and for whom Premium has been paid. Members are sometimes called "You" or "Your" in this Policy.

Minimum Essential Coverage 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 benefits risk pool, or as the Secretary of HHS recognizes.

Network Birthing Center means a Birthing Center, as defined in this section above, who has a written agreement directly with Anthem to provide Covered Services to Members.

Network Diabetes Education Provider means a certified, registered or licensed health care expert in diabetes management who has a written agreement directly with Anthem to furnish diabetes counseling and diabetes education to Members.

Network New Hampshire Certified Midwife (NHCM) means an individual who is certified under New Hampshire law and who has a written agreement directly with Anthem to provide Covered Services to Members.

Network Nutrition Counselor means a registered dietitian practicing independently or as part of a physician practice or hospital clinic and who has a written agreement directly with Anthem to provide nutrition counseling to Members.

Network Primary Care Provider (PCP) means a Network Provider who has a written agreement with Anthem regarding, among other things, willingness to provide Covered Services to Members as a Primary Care Provider.

Network Provider means any Provider (such as, but not limited to: physicians, specialists, health care professionals, health care practitioners or hospitals) that has a written payment agreement with Anthem to provide Covered Services to Members. Network Physicians include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRN) acting within the scope of their licenses.

Network Service means a Covered Service that You receive from a Network Provider.

Non-BlueCard® Provider means a Provider outside New Hampshire that does not have a standard payment agreement directly with the Local Plan.

Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to a Non-Participating Pharmacy.

Our or Ours in this Policy, the words "our" or "ours" refers to Anthem.

Out-of-Network Provider means any Provider that is not a Network Provider. Providers who have not contracted or affiliated with Anthem's designated Subcontractor(s) for the services that are Covered Services under this Policy are also considered Out-of-Network Providers.

Out-of-Network Services means a Covered Service that is not furnished by a Network Provider.

Outpatient means a Member who receives services or supplies when not an Inpatient. "Inpatient" is defined above.

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 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 means the 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 Year means, within the context of a group sponsored plan, or grandfathered and non-grandfathered individual plans, a consecutive twelve (12)-month period during which a health plan provides coverage for health benefits. The consecutive twelve (12)-month period may or may not be a Calendar Year. For an individual policy issued in accordance with the Affordable Care Act of 2010, a Plan Year is a Calendar Year.

Physical Rehabilitation Facility means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Policy means the agreement between a Subscriber and Anthem regarding the terms and limitations of coverage under this health care plan. The Policy includes this document and the Cost-Sharing Schedule contained within it.

Post-Service Claim means any claim for a health benefit to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and the health carrier.

Precertification or Precertify is Anthem's written confirmation that a service is Medically Necessary. Precertification is not a guarantee of payment. Benefits are subject to all of the terms and conditions of the Policy including but not limited to, Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, Network restrictions, other party liability rules and membership eligibility rules stated in this Policy, that is in effect on the date that You receive Covered Services.

Pre-Service Claim means any claim for a benefit under a health plan, with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and the health carrier.

Premium means the periodic charges that must be paid by the Subscriber to maintain coverage.

Prescription Drug (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 insulin, diabetic supplies, and syringes.

Provider means 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 Policy. If You have a question about a Provider not described in this Policy please call the telephone number on the back of Your Identification Card.

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 (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

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.

Self-Administered Drugs means drugs that do not require a medical professional to administer.

Service Area means the State of New Hampshire. The Service Area also includes those cities and towns of Maine, Massachusetts and Vermont whose border directly adjoins the New Hampshire border and whose Providers have written payment agreements directly with Anthem.

Short-term General Hospital means a health care institution having an organized professional and medical staff and Inpatient facilities that care primarily for patients with acute diseases and injuries with an average patient length of stay of thirty (30) days or less.

Skilled Nursing Facility means an institution which is, pursuant to law, in compliance with all applicable state licensing and regulatory requirements and which provides room and board accommodations and twenty-four (24)-hour-a-day nursing care under the supervision of a Physician and/or Registered Nurse (R.N.), while maintaining permanent medical history records.

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.

State means each of the fifty (50) States and the District of Columbia.

Subcontractor. Anthem may subcontract particular services to organizations or entities called Subcontractors having specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such Subcontractors or subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or Customer Service duties on behalf of Anthem.

Subscriber means You, the person who applied for coverage and to whom this Policy is issued.

Tax Dependent has the same meaning as the term Dependent under the Internal Revenue Code.

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

- To file an income tax return for the Benefit Year;
- If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
- That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
- That he, she, or they expect 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.

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 considered 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, or multi-source Brand-Name Drugs.

Tier Four Drugs. This tier contains high cost Drugs. It includes Drugs considered Generic Drugs, single source Brand-Name Drugs, and multi-source Brand-Name Drugs.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

- could seriously jeopardize Your or health or Your ability to regain maximum function, or
- 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 proposed care or treatment.

Us. The word “us” in this Policy refers to Anthem.

Walk-in Center means a free-standing center providing health services without appointments for diagnosis, care and treatment of urgent illness or injury.

We. The word “we” in this Policy refers to Anthem.

Year. Any reference to "year" in this Policy means a Calendar Year, unless specifically stated otherwise. A Calendar Year starts on January 1st and ends on December 31st in any given year.

You, Your and Yours, unless specifically stated otherwise, the words "you," "your" and "yours" refer to You, the person to whom this Policy is issued (the Subscriber) and Your covered spouse or civil union partner and covered dependents-collectively the Members.