Anthem
Individual Market
Silver PPO Pathway X
Schedule of Benefits

Deductible and Out-of-Pocket Maximum	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible - The individual deductible applies if you have coverage only for yourself and not for any dependents. The family deductible applies if you have coverage for yourself and one or more eligible dependents. If you have family coverage, each covered family member needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving benefits that are subject to the deductible.		

Plan Deductible **Individual**	$3,200 per Member	$6,500 per Member
Family	$6,400 per family	$13,000 per family
Out-of-Pocket Maximum **Individual**	$5,100 per Member	$9,750 per Member
Family **(Includes Deductibles, Copayments and Coinsurance)**	$10,200 per family	$19,500 per family
Benefits	**In-Network (INET)** **Member Pays**	**Out-of-Network (OON)** **Member Pays**
Provider Office Visits		
Adult Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met
Infant/Pediatric Preventive Visit	No Cost	50% Coinsurance per visit after OON plan Deductible is met

Primary Care Provider Office Services **(includes services for illness, injury, follow-up care and consultations)**	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after the INET plan Deductible is met $25 Copayment per online visit	50% Coinsurance per visit after the OON plan Deductible is met
Specialist Office Visits	0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Mental Health and Substance Abuse Office Visit	$40 Copayment per visit Deductible is waived for first 3 visits 0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Outpatient Diagnostic Services		
Advanced Radiology (CT/PET Scan, MRI)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Laboratory Services	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Non-Advanced Radiology (X-ray, Diagnostic)	0% Coinsurance per service after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Prescription Drugs		
Retail (30-day supply per prescription) Tier One Prescription Drugs	$5 Copayment per prescription	50% Coinsurance per prescription
Tier Two Prescription Drugs	$60 Copayment per prescription	50% Coinsurance per prescription

Tier Three Prescription Drugs	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $250 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Tier Four Prescription Drugs	50% Coinsurance per prescription after INET plan Deductible is met up to a maximum of $500 per prescription	50% Coinsurance per prescription after OON plan Deductible is met
Mail Order (90 day supply per prescription) Tier One Prescription Drugs	$10 Copayment per prescription	Not Covered
Tier Two Prescription Drugs	$150 Copayment per prescription	Not Covered
Tier Three Prescription Drugs	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Tier Four Prescription Drugs	50% Coinsurance per prescription after INET plan Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy **(**40 **visits per Calendar Year limit combined for physical, speech, and occupational therapy)**	0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Physical and Occupational Therapy **(**40 **visits per Calendar Year limit combined for physical, speech, and occupational therapy)**	0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Other Services		
Chiropractic Services **(up to** 20 **visits per Calendar Year)**	0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Diabetic Equipment and Supplies	0% Coinsurance per equipment or supply after INET plan Deductible is met	50% Coinsurance per equipment or supply after OON plan Deductible is met
Durable Medical Equipment (DME)	0% Coinsurance per DME item	50% Coinsurance per DME

	after INET plan Deductible is met	item after OON plan Deductible is met
Home Health Care Services **(up to** 100 **visits per Calendar Year)**	0% Coinsurance per visit after $50 Home Health Care annual Deductible	25% Coinsurance per visit after $50 Home Health Care annual Deductible
Outpatient Services **(in a hospital or ambulatory facility)**	0% Coinsurance per visit after INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met
Inpatient Hospital Services		
Inpatient Hospital Services (including mental health, substance abuse, maternity, hospice and skilled nursing facility) **(skilled nursing facility stay is limited to** 90 **days per Calendar Year)**	$500 Copayment per Admission after INET plan Deductible is met	$500 Copayment per day up to $1,000 per Admission after OON plan Deductible is met

Emergency and Urgent Care		
Ambulance Services	0% Coinsurance per visit after the INET plan Deductible is met	0% Coinsurance per visit after the INET plan Deductible is met
Emergency Room	$200 Copayment per visit after the INET plan Deductible is met	$200 Copayment per visit after the INET plan Deductible is met
Urgent Care Centers	$50 Copayment per visit after the INET plan Deductible is met	$50 Copayment per visit after the OON plan Deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	No Cost	No Cost
Basic Services	40% Coinsurance per visit after the INET plan Deductible is met	40% Coinsurance per visit after the OON plan Deductible is met
Major Services	50% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the ONN plan Deductible is met
Orthodontia Services **(Medically Necessary only)**	50% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Pediatric Vision Care (for children under age 19).		
Prescription Eye Glasses **(one pair of frames and lenses per year)**	Lenses: $0 Collection Frame: $0 Non collection frame: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam **(one exam per Calendar Year)**	0% Coinsurance per visit after the INET plan Deductible is met	50% Coinsurance per visit after the OON plan Deductible is met

Important Notices about Your Benefits and Cost-Shares

Non-Emergency Ambulance Services Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.

Specialty drugs are limited to a 30 day supply.

Unrelated Donor Searches when approved by Anthem, 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 up to $30,000.

Covered Dental Services are subject to the same Calendar Year Deductible (except as noted) and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this document for a detailed description of services.

Vision benefits are covered for Members to the end of the month in which they turn age 19.available to Members through age 18. Covered Vision Services are not subject to the Calendar Year Deductible, except for Catastrophic plans and where noted. To receive the In-Network benefit, you must use a Blue View Vision Provider. For help finding a Blue View Vision Provider, please visit our website or call the number on your ID card.

Contact Lenses One set of contact lenses (conventional or disposable) every Calendar Year is available only if the eyeglass lenses benefit is not used. Elective Contact Lenses: $0 copayment, Out of Network services not covered.

Frames If you choose to upgrade from a collection frame to a non-collection frame, you will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount agreed

upon by the provider and us. Claims for a non-collection frame must be submitted directly to us. Claim forms are available from Blue View Vision's Customer Service Center by calling 866-723-0515. Mail your complete claim form to the following address along with the original itemized paid receipt that identifies the frame to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Any benefit that applies a Copayment will then be paid in full. By paid in full, it means 100% of the negotiated rate for In-Network, and 100% of the actual billed charges for Out-of-Network.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for non-standard plans) subject to copayment for the first 3 visits, not subject to the Deductible. Subsequent Office Visits are subject to medical Deductible and Coinsurance.

Primary Care and Mental Health and Substance Abuse Provider Office Visits (for standard plans) subject to copayment for the first three (3) visits, not subject to the Deductible. Subsequent Visits subject to Copayment and Deductible.

Subscriber Agreement
Silver PPO Pathway X

Read Your Policy Carefully. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY**!

www.anthem.com

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

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

Issued By:

Anthem Health Plans, Inc. d/b/a

Anthem Blue Cross and Blue Shield
108 Leigus Road
Wallingford, Connecticut 06492

INTRODUCTION

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

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

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

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

This Subscriber Agreement supersedes and replaces any Subscriber Agreement previously issued to you.

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

HOW TO GET LANGUAGE ASSISTANCE

Anthem is committed to communicating with our Members about their health benefits, 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.

RIGHT OF SUBSCRIBER AGREEMENT EXAMINATION

If this Subscriber Agreement is provided to You as a Subscriber, You are permitted to return this Subscriber Agreement by delivering or mailing it to the agent or broker through whom it was purchased, or to Anthem at our Home Office in Wallingford, Connecticut within 10 days after the date of delivery if, after examination of the Subscriber Agreement, you are not satisfied with it for any reason. If you return this Subscriber Agreement, it will be deemed void from the beginning and any and all claims paid will be retracted and any Premiums paid will be refunded. This right to examine the Subscriber Agreement does not apply at renewal.

TABLE OF CONTENTS

INTRODUCTION

"You" or "your" refers to the Subscriber or the Dependent of the Subscriber who is named on the Identification (ID) Card. The Dependent Member is a covered Dependent of the Subscriber. "We," "us," and "our" refer to Anthem Blue Cross and Blue Shield ("Anthem"). Other terms are defined in the "Definitions" section of the Subscriber Agreement.

Benefit Program

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

The Subscriber Agreement explains the benefits, exclusions, limitations, terms and conditions of membership and services and the guidelines which must be adhered to in order for you to obtain benefits for Covered Services.

Anthem is a managed care company, therefore it is required that the Member observe all guidelines and procedures for obtaining Covered Services.

This Benefit Program offers you the flexibility to determine how you wish to access benefits and obtain Covered Services. There are two levels of coverage under this Benefit Program; In-Network and Out-of Network coverage. When you visit an Anthem PPO Network Provider for Covered Services, you are responsible for the In-Network Cost-Shares. Your benefits are highest when you visit an Anthem PPO In-Network Provider.

If you visit an Out-of- Network Provider for Covered Services, you are responsible for Out-of-Network Cost-Shares. You are also responsible for any charges in excess of the Maximum Allowed Amount (MAA).

When establishing the MAA for the Out-of-Network Providers, Anthem considers industry costs, reimbursement and utilization data indices, including geographically based national reimbursement data.

Please see the Schedule of Benefits for the applicable Cost-Shares for both options. In addition to listing the Cost-Shares that are your responsibility, this Schedule of Benefits also contains benefit maximums for specific types of coverage.

Anthem has a statewide network of Participating Physicians, Providers and Hospitals from which may obtain In-Network services. For a geographic distribution of these Providers, please refer to the Provider Directory.

Member Notification

Anthem is not responsible for notifying a Physician's patients when the Provider leaves the Participating Provider network, except that in the case of a primary care Physician the following applies: Anthem will provide written notice to each affected Member at his or her last known address no later than 30 days after sending or receiving notice of the termination or withdrawal of their primary care Physician from the Network. Although the Provider Directory is updated regularly to keep Members informed of a Provider's participating/non-participating status; we recommend that you verify with the Provider their participating status prior to incurring services.

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

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

None of Anthem's employees or the providers with whom it contracts with to make medical management decisions are paid or provided incentives to deny or withhold benefits for services that are Medically Necessary and are otherwise covered under the Subscriber Agreement. In addition, Anthem requires certain members of our clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying benefits for services that are Medically Necessary and are otherwise covered under the Subscriber Agreement.

The Member is entitled to the Covered Services described in the Covered Services Section of the Subscriber Agreement. The Covered Services therein are subject to the terms; conditions; and limitations of the Subscriber Agreement

Inter-Plan Arrangements

Out-of-area services

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

Typically, when you access medical care outside Anthem service area, you will obtain it from providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non--participating providers. . Please note, urgent and emergency care are always considered In-Network services as described elsewhere in this Subscriber Agreement. Anthem payment practices are generally described 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 Evidence of Coverage.

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.

Non-Participating 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 a Non-Participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of Non-Participating, 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 Non-Participating 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 Participating 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 a non-participating 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 ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

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

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization 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.

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

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

First - Make an Office Visit with Your PCP

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

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

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

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

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

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

Member Services

Member Services is available to explain policies and procedures and answer questions regarding the availability of benefits.

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

Anthem Blue Cross and Blue Shield
Member Services
P.0. Box 1030
North Haven, Connecticut 06473

Office Hours Monday through Friday	8:00 a.m. to 5:00 p.m.
Member Service Telephone	Toll free – 1 (855) 738-6644
Home Office Address	You may visit our home office during normal business hours at 108 Leigus Road, Wallingford, CT 06492

After Hours Care

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

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 plan.
- Work with your doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and Federal laws.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - our company and services.
    - our network of health care Providers.

  - your rights and responsibilities.
  - the rules of your health plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your health plan and any care you receive.
  - any covered service or benefit decision that your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care you may get in the future. This includes asking your doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by calling the Member Services number located on the back of your ID Card or by visiting Anthem.com.

Or contact your local insurance department:

CONNECTICUT
Phone: 800-203-3447
Write: State of Connecticut Insurance Department
P.O. Box 816
Hartford, CT 06142-0816

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health plan rules and policies.
- Choose an In-network primary care physician, also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with respect.
- Keep all scheduled appointments. Call your health care provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care providers to make a treatment plan that you all agree on.
- Inform your health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care providers.
- Give us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health plan. This may include information about other health insurance benefits you have along with your coverage with us.
- Inform Member Services if you have any changes to your name, address or family members covered under your plan.

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

We want to provide high quality benefits and customer service to our members. Benefits and coverage for services given under the plan are overseen by your Certificate of Coverage, Member Handbook or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

ELIGIBILITY

Eligibility

The benefits, terms and conditions of this Subscriber Agreement 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 Subscriber Agreement, 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 Connecticut; and meet the following applicable residency standards;

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

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

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

- Not be living in an institution
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
- Not be emancipated
- Not be receiving optional State supplementary payments (SSP)
- 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 enrolled in Medicare Parts A/B and or D;
10. Not be covered by any other group or individual health benefit plan.

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

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

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

For tax households with Members in multiple Exchange Service Areas:

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

Eligible Dependents

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 Subscriber Agreement, 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 26.
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

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

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

Temporary custody is not sufficient to establish eligibility under this Subscriber Agreement.

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

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

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

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

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 61 days from the date of birth. Coverage for newborns will continue beyond the 61 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. Notice is not required unless premium is due. The form must be submitted along with the additional Premium, if applicable, within 61 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 Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded with 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 Subscriber Agreement, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Subscriber Agreement, and once approved by the Exchange, we will provide the benefits of this Subscriber Agreement 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 Subscriber Agreement 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 or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship. 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 or appointment of guardianship of occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the month following the event, as long as the application is received within 30 days of the event.

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

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works the 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 dates 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 Subscriber Agreement. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

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

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

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Subscriber Agreement 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 Subscriber Agreement for each Subscriber.

MANAGED BENEFITS – Managed Care Guidelines

Subject to the terms and conditions of the Subscriber Agreement, a Member is eligible for benefits for Covered Services for Medically Necessary Care when prescribed or ordered by a Physician and when in accordance with the provisions of this Managed Benefits Section.

Introduction

A Member's right to benefits for Covered Services provided under this Subscriber Agreement is subject to certain policies or guidelines and limitations, including, but not limited to: Anthem Medical Policy; Prior Authorization; Concurrent Review; and Case Management. A description of each of these provisions is described in the Managed Care Guidelines that explains its purpose; requirements; and effects on benefits. Failure to follow the Managed Care Guidelines for obtaining Covered Services will result in a reduction or denial of benefits.

NOTICE: Prior Authorization does NOT guarantee coverage for or the payment of the service or procedure reviewed. The Member should contact his/her Physician and/or Anthem to be sure that Prior Authorization has been obtained.

The Member should consult his/her Physician concerning courses of treatment and care. Notwithstanding any benefit determination, the Member and the Member's Physician must determine what care and/or treatment is received.

Questions regarding Managed Care Guidelines or to determine which services require Prior Authorization can be addressed by calling the telephone number on the back of the Member's Identification Card or refer to Anthem's website at: www.anthem.com.

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Your Responsibilities When Obtaining Health Care – Prior Authorization

Requesting Approval for Benefits

Your Subscriber Agreement includes the processes of precertification, predetermination and post service clinical claims review to decide when services should be covered by Anthem. Their purpose is to aid the

delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Participating 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 if you have not first tried other Medically Necessary and more cost effective treatments.

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Subscriber Agreement 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 Subscriber Agreement or is Experimental/Investigative as that term is defined in this Subscriber Agreement.

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

Who is responsible for Precertification	
Services given by an In-Network/Participating Provider	**Services given by a BlueCard/Out-of-Network/Non-Participating Provider**
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by us, notwithstanding that it might otherwise be found to be investigational as that term is defined in the Plan otherwise .Your Subscriber Agreement take 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. To ask for this information, call the Precertification phone number on the back of your Identification Card.

In addition, we may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

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

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

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

Request Categories

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

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Urgent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Urgent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request
Request for Mental Health and Substance Abuse Services	
Prospective Urgent – Levels of care include: Inpatient Services, Residential Treatment, Partial Hospitalization, or Intensive Outpatient Programs.	24 hours from the receipt of the request
Prospective Non-Urgent – Outpatient Services	15 calendar days from the receipt of the request
Continued Stay Review Urgent	24 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

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

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

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

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

Health Plan Individual Case Management

Our health plan case management programs (Case Management) helps 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.

COVERED SERVICES

This Section lists Covered Services and the benefits We pay. This Benefit Program shall provide benefits for the Covered Services described in this section when performed by a Participating Physician, Participating Provider, Participating Hospital and subject to the Managed Benefits Section of this Subscriber Agreement. The Member is responsible for the applicable Deductible and Coinsurance if the Covered Services are rendered by a Participating Physician, Participating Provider or Participating Hospital. Please refer to the Schedule of Benefits for specific Cost-Shares and limitations.

The following conditions apply to the description of Covered Services referenced in this section:

1) All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Subscriber Agreement.
2) To receive maximum benefits for Covered Services, you must follow the terms of the Subscriber Agreement, including, if applicable, receipt of care from your primary care physician, use of in-network providers, and obtaining any required Prior Authorization.
3) Benefits for Covered Services are based on the Maximum Allowable Amount for such service.
4) If you have an out-of-network benefit and use a Non-Participating Provider, you are responsible for the difference between the Non-Participating Provider's charge and the Maximum Allowable Amount, in addition to any applicable Cost-Shares. Anthem cannot prohibit Non-Participating Providers from billing you for the difference in the Non-Participating Provider's charge and the Maximum Allowable Amount. If you do not have an out-of-network benefit, your entire claim will be denied.
5) Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of the Subscriber Agreement.
6) Anthem's payment for Covered Services will be limited by any applicable Cost-Shares or annual payment limit in the Subscriber Agreement, including the Schedule of Benefits.
7) 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.
8) Anthem bases its decisions about referrals, Prior Authorization, Medical Necessity, experimental services and new technology on medical policy developed by Anthem. Anthem may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

AMBULANCE/MEDICALLY NECESSARY TRANSPORTATION SERVICES

This Subscriber Agreement Covers:

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 an In-Network Hospital; or

3) Between a Hospital, Skilled Nursing Facility (ground transport only) or Approved Facility.

You must be taken to the Facility that can give care for Your condition.

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 Subscriber Agreement's Maximum Allowed Amount.

Ground Ambulance

Services are subject to medical necessity review by Anthem.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by Anthem. Anthem retains the right to select the Air Ambulance provider, except in an emergency. This includes fixed wing, rotary wing or water transportation

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

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type 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.

DENTAL CARE (PEDIATRIC)

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this plan.

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

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

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

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery or orthodontic care.

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

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

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

Dental Providers

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

Please call our Member Service's department at the telephone number on the back of your Identification Card for help in finding an In-Network dentist or visit our website at www.anthem.com/mydentalvision. Please refer to your ID card for the name of the dental program that In-Network Providers have agreed to service when you are choosing an In-Network dentist.

Pediatric Dental

We cover the following dental care services for Members to the end of the month in which they turn age 19.

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 1 time per 6-month period.

Comprehensive oral evaluations will be covered once per dental office, up to the 1 time per 6-month period limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 1 time per 6-month period limit will apply.

Radiographs (X-rays)

Bitewings - 1 series per 6-month period.

Periapical – The first film is not covered on the same date of service as bitewings or panoramic film.

Full Mouth (Complete Series) or Panoramic – covered 1 time per 36 month period.

Dental Cleaning (Prophylaxis) - covered 1 time per 6-months per provider. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Baby Care Early Dental Examination and Fluoride Varnish where an oral health screen, oral health education and fluoride varnish are applied to children's teeth during well child examinations is covered to age 4.

Fluoride Treatment including topical application of fluoride or therapeutic fluoride varnish (for members with moderate to high risk of dental decay)- Covered 1 time per 6 month period.

Sealants - covered 1 time in a 5 year period per tooth for permanent first and second molars.

Oral Hygiene Instructions – Covered 1 time per 12-month period for dependent children through the age of 3.

Space Maintainers. Repair or replacement of lost/broken appliances are not covered.

Recement Space Maintainers.

Basic Restorative Services

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

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

- **Composite (white) Resin Restorations** Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.
- Limitation 1 time per year to same surface by same Provider. Primary teeth which are about to come out are not covered.
- Restorative Temporary Sedative Filing. Covered only when done to treat dental pain requiring emergency treatment.

Basic Tooth Extractions

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

Surgical incision and drainage of abscess.

Endodontic Services

Endodontic Therapy on Primary Teeth

- Therapeutic Pulpotomy for primary or permanent teeth

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy

Apexification – Includes all visits to complete the service.

Oral Surgery Services

Complex Surgical Extractions

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

Surgical removal of 3rd molars are only covered if the removal is associated with symptoms or oral pathology.

Intravenous Conscious Sedation, IV Sedation, and General Anesthesia – Covered only when given with covered complex surgical services. Nitrous Oxide is covered when patient is under 8 years old, or if the child is over 8 years old and has been diagnosed with a behavioral problem.

Periodontal Services

Gingivectomy – Covered only for severe side effects caused by medicine.

Major Restorative Services

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

Pre-fabricated or Stainless Steel Crown

Permanent Crowns Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Occlusal Guards, by report

Fabrication of athletic mouthguard.

Prosthetic Services

Reline and Rebase – Limited to once in any two year period.

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)

Removable Prosthetic Services (Dentures and Partials) – Limited to 1 in 5 year period.

LIMITATION: A removable partial denture is not covered if the member has at least 8 posterior teeth in occlusion and no missing anterior teeth.

Recement Fixed Prosthetic

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover orthodontic care that is Dentally Necessary Orthodontic Care.

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

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

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

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

Benefits do not include:

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

Orthodontic Payments

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

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

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

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

Dental Appeals

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

Anthem Blue Cross and Blue Shield

P. O. Box 1122

Minneapolis, MN 55440-1122

Please see “Member Appeal Process” section for a detailed explanation of the appeal process.

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 Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, SUPPLIES & APPLIANCES

Please Note: Certain Durable Medical equipment may not require Prior Authorization. Contact Customer Service before any such equipment is obtained to determine if Prior Authorization is required.

This Subscriber Agreement Covers:

Durable Medical Equipment which improves the function of a malformed body part, or prevents or retards further deterioration of the Member's medical condition.

Prosthetic Devices, when prescribed, whether surgically implanted or worn as an anatomic supplement and subject to the following:

- Repair, replacement, fitting, and adjustments are covered when made necessary by normal wear and tear or by body growth or change.
- In cases of a tumor of the oral cavity, non-dental Prosthetic Devices, including maxillo-facial Prosthetic Devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional Appliances essential for the support of such Prosthetic Devices.
- Appliances such as a leg, arm, back or neck brace or artificial legs, arms or eyes or any prosthesis with supports, including replacement if a Member's physical condition changes.

Diabetic equipment and supplies.

Ostomy bags, catheters and supplies required for their use, and any other Medically Necessary ostomy-related appliances including; but not limited to: collection devices; irrigation equipment and supplies; and skin barriers and protectors.

External breast prosthesis following mastectomy for malignancy or other disease of breast tissue. Prior authorization is not applicable to prostheses pursuant to the Women's Health and Cancer Rights Act of 1998.

Hypodermic needles or syringes prescribed by a licensed practitioner for the purpose of administering medications for medical conditions provided such medications are covered under this Subscriber Agreement.

Hearing aid coverage available one per ear every 24 months.

Surgically Implanted Hearing Devices

Wigs if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Subscriber Agreement for information on how to obtain Prior Authorization.

Covered Services do not include (except as otherwise stated above as covered):

Dental devices, household and personal comfort items, eyeglasses, hearing aids, orthopedic shoes or other supportive or corrective devices for the feet; or any other item not specifically defined in the definition of Appliances.

Repair and replacement of Prosthetic Devices and Appliances made necessary because of loss or damage caused by misuse or mistreatment.

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

HOME HEALTH CARE

This Subscriber Agreement Covers:

After an Admission – commencing within 7 days after discharge from the Hospital.

In lieu of an Admission.

Terminal Illness – upon diagnosis by a Physician

Skilled nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) under the supervision of a R.N. when the services of a R.N. are not available.

Skilled, progressive and rehabilitative services of a licensed physical therapist.

Other Covered Services:

Occupational, speech and respiratory therapy;

Medical and surgical supplies and prescribed Durable Medical Equipment;

Prescription Drugs dispensed from a retail Pharmacy;

Oxygen and its administration;

Home health aide services consisting primarily of patient care of a medical or therapeutic nature;

Laboratory services;

Dietary services;

Transportation to and from a Hospital for treatment, re-admission or discharge by the most safe and cost-effective means available.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

The Member must be essentially confined at home and home health care services must be rendered for treatment of the same illness or injury for which the Member was hospitalized.

Every four hours of Covered Services rendered by a home health aide will be charged as one visit.

Covered Services do not include:

Meals, personal comfort items and housekeeping services.

Nursing services provided in the home by a relative, even if a registered nurse or a licensed practical nurse.

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

HOSPICE CARE

This Subscriber Agreement Covers:

Hospice Care

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

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a qualified 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 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 certificate, are provided as set forth in other parts of this certificate.

HOSPITAL SERVICES

This Subscriber Agreement Covers:

Inpatient Hospital Services:

Room and board for a semi-private Hospital room. If a private room is used, this Benefit Program shall only provide benefits for Covered Services up to the cost of the semi-private room rate, unless Anthem determines that a private room is Medically Necessary.

Following a mastectomy, benefits for Covered Services will be provided as follows:

At least 48 hours after a mastectomy or lymph node dissection unless otherwise agreed upon by the Member and Physician.

Inpatient and Outpatient Hospital services and supplies:

Use of an operating, delivery and treatment room, and equipment (including intensive care);

Prescribed drugs;

Administration of blood and blood processing;

Anesthesia, anesthesia supplies and services;

Medical and surgical dressing, supplies, casts and splints;

Diagnostic services;

Rehabilitative and restorative physical therapy and occupational therapy and speech therapy for treatment expected to result in the reasonable improvement of a Member's condition;

Radiation therapy;

Laboratory tests;

X-ray or imaging studies;

Outpatient surgery in a licensed ambulatory surgical center;

Pre-admission testing;

Tests and studies required in connection with a scheduled Admission for surgery;

Services for hemodialysis or peritoneal dialysis for chronic renal disease, including equipment, training and medical supplies until the Member is enrolled in the Medicare End Stage Renal Disease program;

Services associated with accidental consumption or ingestion of a controlled drug or other substance.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

The benefits for a General Hospital with a participating agreement are unlimited.

The Specialty Hospital benefit period for other than Mental Health and Substance Abuse services is 90 days per Member per Calendar Year.

Benefits for services rendered outside of the United States are unlimited days.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is subject to Out-of-Pocket Limits.

If a Member is admitted as an Inpatient as a result of Outpatient surgery, the Member must notify Anthem within 2 business days of the Admission. Please refer to the Managed Benefits Section of this Subscriber Agreement for information on how to notify us of your Admission.

Pre-Admission testing must be rendered to a Member as an Outpatient prior to the scheduled Admission and not repeated upon Admission for surgery. The Member will be responsible for the charges for Pre-Admission testing if the Member cancels or postpones the scheduled Admission.

Inpatient and Outpatient Hospital Dental Services - Anesthesia, nursing and related hospital charges for Inpatient dental services; Outpatient Hospital dental services; or one day dental services are covered if deemed Medically Necessary by the treating dentist or oral surgeon and the patient's primary care Physician in accordance with Prior Authorization requirements and (1) the patient has been determined by a licensed dentist in conjunction with a licensed primary care Physician to have a dental condition of sufficient complexity that it requires Inpatient services; Outpatient Hospital dental services; or one day dental services, or (2) the patient has a developmental disability, as determined by a licensed primary care Physician, that places him or her at serious risk.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

HUMAN ORGAN AND TISSUE TRANSPLANT (Bone marrow/Stem Cell) SERVICES

This Subscriber Agreement Covers:

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 Booklet.

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

Live Donor Health Services

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

Transplant Benefit Period

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

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

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

Transportation and Lodging

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

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

- Child care,
- Mileage within the medical transplant facility city,

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

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

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

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

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

MATERNITY/FAMILY PLANNING

This Subscriber Agreement Covers:

Benefits for Inpatient maternity Covered Services are as follows:

1) In accordance with C.G.S. 38a-530c, Inpatient care for a female Member and newborn will be provided for a minimum of 48 hours following a vaginal delivery, and for a minimum of 96 hours following a caesarean delivery, unless otherwise agreed upon by the Member and the Participating Physician.
2) The time period shall commence at the time of delivery.
3) If the Member and Participating Physician agree to an earlier discharge time, benefits for Covered Services shall be provided for a follow-up home visit within 48 hours of discharge and an additional follow-up visit within 7 days.

Covered Services

Therapeutic and Elective Abortions

Prenatal and Postnatal Care.

Infertility services; Prior Authorization is required.

- Ovulation induction coverage is limited to a lifetime maximum of 4 cycles;
- Intrauterine insemination is limited to a lifetime maximum of 3 cycles;
- In-vitro, GIFT, ZIFT and low tubal ovum transfer is limited to a maximum of two cycles combined with not more than two embryo implantations per cycle-with each fertilization or transfer counting as one cycle.

Infertility drugs (with infertility diagnosis).

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

MEDICAL EMERGENCY

This Subscriber Agreement Covers:

Ambulance services when the Member's condition at the time of the treatment is confirmed to have been a Medical Emergency.

Medical Emergency services provided at a Hospital's emergency room.

Medical Emergency services provided by a Physician.

Notes:

Please refer to the Schedule of Benefits for any applicable Cost-Shares and limitations.

Emergency medical condition (Medical Emergency) means a medical condition manifesting itself by acute symptoms or final diagnosis 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 (Medical Emergency) 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 means, with respect to an emergency medical condition:

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.

This Benefit Program shall only provide benefits for Medical Emergency services if the care is determined to be for a Medical Emergency. All Admissions resulting from a Medical Emergency must be approved by Anthem within 2 business days of the diagnosis, care or treatment of the Medical Emergency.

If the emergency requires that the Member be taken to the Hospital, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Hospital is a Participating Hospital or Non-Participating Hospital.

If the emergency requires that the Member receive diagnosis, care or treatment from the first available Physician or Provider, this Benefit Program shall provide benefits for Covered Services for the Medical Emergency regardless of whether the Physician or Provider is a Participating Physician or Provider or Non-Participating Physician or Provider.

If the Medical Emergency requires a Member's Admission to a Non-Participating Hospital, this Benefit Program shall provide benefits for Covered Services as if the services were received at a Participating Hospital only through the day when the Member can be transferred to a Participating Hospital, as determined by Anthem.

Claims for services rendered to the Member shall be subject to review by Anthem. Based on Anthem's review, the Member may be liable for Cost-Shares, or the full cost of all services rendered if Anthem determines that the services provided were not for a Medical Emergency. Medical Emergency Covered Services are limited to the treatment rendered during the initial visit only.

All services deemed by Anthem to be Medical Emergencies are eligible for benefits as if rendered by Participating Physicians, Participating Providers or Participating Hospitals benefits as specified in the Schedule of Benefits and Benefit Chart.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

This Subscriber Agreement Covers:

Inpatient Services in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

Outpatient Services including office visits and treatment in an Outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive Outpatient programs.

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

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

Notes:

You can get Covered Services from the following Providers:

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

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

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.

ORAL SURGERY

This Subscriber Agreement Covers:

For office based services see Physician Medical/ Surgical Section.

For Hospital based services see Hospital Service Section.

The following are Covered Services, as determined by Anthem:

1) An initial visit for the prompt immediate repair of trauma, due to an accident or injury, to the jaw, natural teeth, cheeks, lips, tongue and/or the roof of the mouth. Benefit available for services provided during the initial visit, include but are not limited to the following:
    - Evaluation;
    - Radiology to evaluate extent of injury;
    - Treatment of the wound; tooth fracture or evulsion.

    No additional benefits will be provided for any services rendered after the initial visit, including but not limited to: follow-up care, replacement of sound natural teeth, crowns, bridges, and prosthetic devices.
2) Oral surgical services for treatment of lesions, tumors, and cysts on or in the mouth. Oral surgery services for treatment related to tumors of the oral cavity, treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw, temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) and temporomandibular disease (TMD) syndrome.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is subject to Out-of-Pocket Limits.

Covered Services do not include:

In the case of injury to the oral cavity, non-covered Prosthetic Devices include, but are not limited to, plates, bridges, dentures or caps/crowns.

Injury to teeth or soft tissue as a result of chewing or biting shall not be considered an accidental injury.

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

OTHER PROVISIONS

This Subscriber Agreement Covers:

Services from birth to age three for Medically Necessary early intervention Covered Services for a Member and his/her family Members provided as part of an individualized family service plan. Payment of such services shall not be applied against annual limits specified in this Subscriber Agreement.

Autism Services: Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs), identified and ordered in accordance with a treatment plan developed by a licensed physician, psychologist or clinical social worker pursuant to a comprehensive evaluation are covered as prescribed by State law as follows.

- Behavioral Therapy for children up until their 15th birthday, when provided or supervised by a behavioral analyst who is certified by the Behavioral Analyst Certification Board, or a licensed physician, or a licensed psychologist.
- Direct psychiatric or psychological services and consultations provided by a licensed psychiatrist or psychologist.
- Occupational, physical and speech/language therapy provided by a licensed therapist.

This occupational, physical and speech/language therapy benefit is not subject to any benefit maximum for outpatient rehabilitative therapy listed in your Schedule of Benefits. There is no coverage for special education and related services, except as described above.

Blood derivatives when purchased through a blood derivative supplier.

Blood lead screenings and clinically indicated risk assessments when ordered by a Primary Care Physician

Blood and blood plasma

Bone Density

Amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases including cystic fibrosis.

Clinical Trial :

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or

treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

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

    a) The National Institutes of Health.

    b) The Centers for Disease Control and Prevention.

    c) The Agency for Health Care Research and Quality.

    d) The Centers for Medicare & Medicaid Services.

    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

        i. The Department of Veterans Affairs.

        ii. The Department of Defense.

        iii. The Department of Energy.

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

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

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

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial 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 Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Hospitalization shall for Routine Patient Care Costs include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of-Network Hospitalization will be rendered at no greater cost-share to the member than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

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

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Coverage for Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician.

Diseases and Abnormalities of the Eye: Annual retina exams for members with glaucoma or diabetic retinopathy

Nutritional Counseling for illnesses requiring therapeutic dietary monitoring, including the diagnosis of obesity

Outpatient self-management training for the treatment of diabetes including medical nutrition therapy. Note: Screenings for gestational diabetes are covered under "Preventive Care".

Intravenous and oral antibiotic therapy for the treatment of Lyme Disease.

Medically Necessary Pain Management medication and procedures when ordered by a pain management specialist.

Coverage for wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Physician.

Notes:

Prior Authorization is required for the purchase of Specialized Formula. Please refer to the Managed Benefits Section of this Subscriber Agreement for information on how to obtain Prior Authorization.

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Payment for birth to age three services shall not be applied against annual limits specified in this Subscriber Agreement.

Outpatient diabetes self-management training is covered if prescribed by a licensed health care professional and performed by a certified, licensed or registered health care professional trained in diabetes care and operating within the scope of their licensure. Benefits are provided for 10 hours of initial training, 4 hours of additional training because of changes in the individual's condition and four hours of training required by new developments in the treatment of diabetes. Please refer to your directory for a listing of Participating Providers and Hospitals where Covered Services may be obtained. Note: Screenings for gestational diabetes are covered under "Preventive Care".

Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease specialist or neurologist.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

PHYSICIAN MEDICAL/SURGICAL SERVICES

This Subscriber Agreement Covers:

Medical services for the treatment of an illness or injury.

Medical office visits, specialist consultations, injections and home visits by a Physician.

Chiropractic services, evaluation and treatment.

Allergy testing.

Corneal Pachymetry (measurement of the thickness of the cornea) is covered after the applicable Cost-Share amount. The Cost-Share amount depends on where the test is rendered. Coverage is available for one complete test per lifetime without Pre-Authorization. Repeat corneal pachymetry tests require Pre-Authorization.

Genetic Testing for Members who have or are suspected of having a clinical genetic disorder.

Inpatient Hospital/Inpatient Facility visits during a covered Admission.

Acute Psychiatric Care while an Inpatient at a Hospital or Inpatient Facility. 1 session per Inpatient day

Inpatient consultations by other than the attending Physician. 2 per 30 day period.

For breast implants which were surgically implanted as a result of a mastectomy, benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants, benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation.

Surgical assistant services.

In accordance with C.G.S. 38A-490c, coverage for Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for individuals eighteen years of age or younger if such processes and appliances are prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association.

In accordance with C.G.S. Section 38a-492l, coverage for each child diagnosed with cancer neuropsychological testing ordered by a licensed physician, to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment is covered. No prior-authorization is required.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Anthem will pay for the services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.

Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

Covered Services do not include:

Initial medical care for scheduled Admissions for surgery. This means the first non-surgical services rendered to a Member as an Inpatient by the attending Physician.

Separate charges for pre and post-operative care.

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

PREVENTIVE SERVICES

This Subscriber Agreement Covers:

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Subscriber Agreement with no Deductible, Co-payments or Coinsurance from the Member as explained in your Schedule of Benefits. That means Anthem pays 100% of the Maximum Allowable Amount. These services fall under four broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:

   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. including the following:

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

   b) Screenings and/or counseling, where applicable, for: Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence. Breastfeeding support, supplies, and counseling. To obtain In-Network benefits, breast pumps and supplies must be received from a Participating Provider. Breast pumps are limited to one per pregnancy or as required by law.

   c) Gestational diabetes screening.

Other services include:

- Adult Physical Exam
- Prenatal and Postnatal Care
- Routine Gynecological exam
- Baseline routine mammography
- Blood lead screenings and clinically indicated risk assessments when ordered by a Primary Care Physician
- Blood and blood plasma

You may call Member Service using the number on your ID card for additional information about these services.

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.

Screenings and other services are generally covered as preventive care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the diagnostic services benefit.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

PRESCRIPTION DRUGS

This Subscriber Agreement Covers:

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

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

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

Prescription Drug List

We also have a Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also

based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

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

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

Your Benefit Program limits Prescription Drug coverage to those Drugs listed on our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain drugs if they are not on the prescription drug list. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this formulary from time to time. A description of the Prescription Drugs that are listed on this formulary is available upon request and at www.anthem.com. Drugs not on the Anthem Prescription Drug List are not covered unless determined by us to be Medically Necessary. In order for a Prescription Drug that isn't part of our Prescription Drug List to be considered Medically Necessary, the Physician must substantiate to us, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

Exception Request for a Drug not on the Prescription Drug List

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

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

If coverage is denied You can refer to the "Member Appeal Process" section of this Subscriber Agreement.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;

- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)
- Prescription Drugs used to treat infertility.

Where You Can Obtain Prescription Drugs

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

Retail

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

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

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are 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.

Mail Order

Your 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 (maintenance medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Summary of Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, 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 Member Service telephone number on the back of your Identification Card.

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. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling 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 Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program Member Service department at the telephone number on the back of your Identification Card for availability of the Drug or medication.

Specialty Pharmacy

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

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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

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

You or your physician may order your specialty Drug from the Specialty Preferred Program by calling the Member Service telephone number on the back of your Identification Card. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your specialty drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

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

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

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, we will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next

business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and medically necessary. You may have to pay the applicable Copayment/coinsurance, if any.

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

Important Details About Prescription Drug Coverage

Your Benefit Program includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before we can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

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

Drug Utilization Review

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

Prior Authorization

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

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

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

Step Therapy

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

Administered by a Medical Provider

Your Benefit Program also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables that must be administered by a Provider.

This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

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

Additional Features

Day Supply and Refill Limits

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

Half-Tablet Program

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

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted prescription drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at a retail pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these prescription drugs by calling the toll-free Member Services number on your member ID card or log on to the member website at www.anthem.com.

Special Programs

Except where prohibited by Federal Regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, we may allow access to network rates for drugs not listed on our formulary.

Claims and Member Service

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

The address of Anthem is:

Anthem Blue Cross and Blue Shield

Member Services
108 Leigus Road
Wallingford, CT 06492

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

Drugs for which Prior Authorization is currently required are below:

Actimmune	Actonel	Adcirca	Afinitor
Afinitor Disperz	Aldurazyme	Alocril	Alomide
Amifostine	Amnesteem	Amphetamine Salt Combo	Ampyra
Anastrozole	AndroGel	Apokyn	Aranesp
Aripiprazole	Avandia	Avita	Avodart
Axert	Azelex	Baraclude	Benlysta
Bepreve	Bexarotene	Bosulif	Botox
Buphenyl	Buprenorphine	Buprenorphine-naloxone	Butorphanol nasal spray
Bydyreon	Capecidabine	Caprelsa	Celecoxib
Cerezyme	Chlorpromazine	Cialis 2.5mg, 5mg	Cimzia
Ciprodex	Clavaris	Clonidine ER	Clozapine
Clozapine ODT	Colcrys	Cometriq	Copaxone
Crestor	Dexilant	Dexmethylphenidate	Dexmethylphenidate ER
Dextroamphetamine	Dextroamphetamine ER	Diclofenac topical gel	Dificid
Doxycycline, delayed release	Duloxetine	Elaprase	Elelyso
Elidel	Eliphos	Emadine	Emcyt
Enablex	Enbrel	Enoxaparin	Entecavir
Epivir HBV	Erivedge	Esomeprazole	Eszopiclone
Exemestane	Exjade	Extavia	Fabrazyme
Fanapt	Fentanyl lozenge	Fentanyl transdermal Patch	Ferriprox
Finasteride	Firmagon	Flector Transdermal Patch	Flunisolide Nasal Spray
Fluphenazine	Focalin XR	Fondaparinux	Forteo
Fosamax Plus D	Fosrenol	Fragmin	Frova
Gleevec	Guanfacine ER	Haloperidol	Harvoni
Hizentra	Horizant	Humira	Hydromorphone ER
Iclusig	Imiquimod	Incivek	Increlex
Inlyta	Intron A	Invega	Itraconazole
Jakafi	Janumet	Janumet XR	Januvia
Kapvay	Kineret	Kuvan	Latuda
Letairis	Leukine	Leuprolide	Levetiracetam
Linezolid	Livalo	Loxapine	Lyrica
Mekinist	Metadate	Methamphetamine	Methoxsalen
Methylphenidate	Methylphenidate ER	Methylphenidate LA	Minocycline ER
Modafinil	Moderiba	Morgidox	Mozobil
Mybetriq	Myozyme	Naglazyme	Nateglinide
Neulasta	Neupogen	Nexavar	Nexium
Nucynta ER	Nulojix	Nuvigil	Olanzepine
Omaris	Omnitrope	Omontys	Onglyza
Orap	Orencia	Oxandrolone	Oxycontin

Pataday	Patanol	Pegasys	Pegintron
Perphenazine	Picato	Procrit	Prolia
Promacta	Pulmozyme	quetiapine	Rebif
Relistor	Relpan	Remicade	Remodulin
Renvela	Revlimid	Ribasphere	Ribasphere Ribapak
Ribavirin	Risperidone	Rituxan	Rozerem
Samsca	Sandostatin LAR	Saphris	Seroquel XR
Sildenafil 20mg	Simponi	Simvastatin 80mg	Somavert
Sovaldi	Sprycel	Stivarga	Strattera
Stribild	Sutent	SymlinPen	Synarel
Tacrolimus	Tarceva	Targretin	Tasigna
Tazorac	Terbinafine	Tev-Tropin	Thalomid
Thioridazine	Thiothixene	Topiragen	Topiramate
Tradjenta	Trelstar	Trelstar Depot	Tretinoin
Trifluoperazine	Tykerb	Tysabri	Tyzeka
Uloric	Vancomycin capsule	Ventavis	Vibryd
Victoza	Viread	Votrient	VPRIV
Vyvanse	Xalkori	Xenazine	Xiaflex
Xifaxan	Xtandi	Xyrem	Yervoy
Zaltrap	Zavesca	Zelboraf	Zenatane
Zenzedi	Zetia	Ziana	Ziprasidone
Zoledronic Acid 5 mg/100 mL	Zolinza	Zortress	Zyflo
Zyflo CR	Zytiga	Zyvox	

RECONSTRUCTIVE SERVICES

This Subscriber Agreement Covers:

Anthem will pay for the services of only one Physician in a given specialty if the surgery reasonably could be expected to be performed by one Physician.

Services of surgical assistants are payable as a surgery benefit based on approved surgical assistant procedures when a Hospital or ambulatory surgical facility does not provide surgical assistants through a residential or surgical assistant program.

In addition to the Exclusions and Limitations stated elsewhere in this Subscriber Agreement, the following limitations apply:

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 a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery.

Benefits are available for Medically Necessary reconstructive surgeries, procedures and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

1. Medically Necessary due to accidental injury; or
2. Medically Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
3. Medically Necessary to restore or improve a bodily function; or
4. Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Subscriber Agreement; or
5. Medically Necessary due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998 (see below).

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

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

1. Mastectomy for Gynecomastia;
2. Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants and
3. Port Wine Stain surgery.

Breast Reconstruction Surgery Benefits and the Women's Health and Cancer Rights Act of 1998

If you are receiving covered benefits for a mastectomy, you should know that the Women's Health and Cancer Rights Act of 1998 provides for:

- Reconstruction of the breast(s) on which a covered mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and treatment of physical complications related to all stages of a covered mastectomy, including lymphedema (swelling). Prior authorization is not applicable to such prostheses.

The manner in which services are provided is between you and your physician. Coverage is subject to all of the terms and conditions stated in this Subscriber Agreement. Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in the Plan. You may be entitled to additional benefits as mandated by state law.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Covered Services do not include:

Initial medical care for scheduled Admissions for surgery. This means the first non-surgical services rendered to a Member as an Inpatient by the attending Physician.

Separate charges for pre and post-operative care.

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

SKILLED NURSING FACILITIES

This Subscriber Agreement Covers:

Coverage includes:

1) Skilled nursing care;
2) Rehabilitative and related services; and
3) Semiprivate room and board.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Prior Authorization is required. Please refer to the Managed Benefits Section of this Subscriber Agreement for how to obtain Prior Authorization.

The Hospital Inpatient/Inpatient Facility Coinsurance amount is subject to Out-of-Pocket Limits.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

Room and board charges exceeding the Skilled Nursing Facility's most common semi-private rate shall be excluded.

THERAPY SERVICES

This Subscriber Agreement Covers:

Outpatient Rehabilitation and Habilitative Services

Outpatient physical, occupational, speech and chiropractic therapy;

Outpatient cardiac rehabilitation therapy;

Other Therapy Services

Radiation Therapy

Chemotherapy for the treatment of cancer;

Kidney Dialysis in a Hospital or free-standing dialysis center;

Infusion Therapy – Benefit will be provided for Outpatient Hospital or home Infusion Therapy regimens under the following conditions:

1. A plan of care for such services is prescribed in writing by a Physician (M.D.);
2. Infusion Therapy is limited to:
    - Chemotherapy (including gamma globulin) administered intravenously;
    - intravenous antibiotic therapy;
    - total parenteral nutrition;

- enteral therapy when nutrients are only available by a Physician's prescription;
- intravenous pain management;

3. Covered Services will include supplies, solutions, and pharmaceuticals.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Speech therapy is a Covered Service when prescribed by a Physician (M.D.) and provided by a licensed speech pathologist.

Whether Infusion Therapy is provided in an Outpatient Hospital program or a combined Outpatient Hospital and home program covered under this Subscriber Agreement, the benefits will not exceed the amount as shown on the Schedule of Benefits.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

URGENT CARE SERVICES

This Subscriber Agreement Covers:

Urgent Care services received at a designated Urgent Care Facility or provided by a Participating Physician.

Notes:

Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

Urgent Care Services are only available in Connecticut. Please refer to the BlueCard Program section of this Subscriber Agreement for obtaining emergency services out of Connecticut by utilizing the BlueCard Program.

Urgent Care services will be covered only if the Member's signs and symptoms at the time of treatment are such that Urgent Care services are Medically Necessary as determined by Anthem.

Covered Services do not include:

Please refer to the Exclusions and Limitations Section of this Subscriber Agreement for other services not covered under this Benefit Program.

VISION CARE (Pediatric)

We cover the following vision care services for Members to the end of the month in which they turn age 19. To receive the In Network benefit, you must use a Blue View Vision provider. For help finding a Blue View Vision provider, please visit our website or call the number on your ID card.

We will cover vision care this is listed in this section. See your Schedule of Benefits for the benefit frequencies and your cost share amounts for covered vision care. We will not pay for vision care listed in the "Exclusion and Limitations" section

Routine Eye Exam

Your plan covers a complete eye exam with dilation as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

You have a choice in your eyeglass lenses. 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 at no additional cost when received In Network. If you choose lens options not listed as covered in this booklet, you will have to pay all charges for those options.

Covered standard eyeglass lenses include:

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

Frames

We offer a selection of frames that are covered under this policy.

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 Schedule of Benefits. We offer a selection contact lenses that are covered under this policy.

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. Low vision benefits are available when received from In Network providers.

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

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

EXCLUSIONS AND LIMITATIONS

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:

Adult routine vision exams.

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.

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

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 resulting from cancer.

Charges 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 Subscriber Agreement.

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

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

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 Subscriber Agreement. 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.

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:
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 Subscriber Agreement. “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 & 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 immunosuppresives.
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 forcoverage if we deem it to be experimental/Investigative.

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

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

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

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

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

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

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

For surgical treatment of gynecomastia.

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

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

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

In excess of Our Maximum Allowable Amounts.

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

for which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Subscriber Agreement or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act. For Individuals with a diagnosis of End Stage Renal Disease (ESRD), Individual policies pay secondary to Medicare except during the 3 month waiting period that begins when the Individual starts dialysis.

For missed or canceled appointments.

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

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

For care received in an Emergency Room that is not Emergency Care, except as specified in this Subscriber Agreement. 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 Subscriber Agreement 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 Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Subscriber Agreement or as required by law or unless medically necessary.

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;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

for stand-by charges of a Physician.

Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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 Subscriber Agreement, or recognized by Us.

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

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

For reversal of sterilization.

Sterilizations for Men and Reversals of Sterilizations We do not provide Benefits for sterilizations for men or services to reverse voluntarily induced sterility for men and women.

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

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

Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with CT Department of Insurance Bulletin IC-37. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

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 Subscriber Agreement in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

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

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

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

For the treatment of temporomandibular joint disorder, craniomaxillary disorder or craniomandibular joint disorders and any treatment for jaw, joint or head and neck neuromuscular disorder except as covered under your medical coverage. This includes all appliances.

Services, supplies, and equipment for the following:

- Gastric electrical stimulation.

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

For vision orthoptic training.

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

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

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

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.

The following prescription drug services are not covered:

- Administration Charges Are charges for the administration of any Drug except for covered immunizations as approved by us or the Pharmacy Benefits Manger PBM.
- Clinically-Equivalent Alternatives Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
- Compound Drugs

- Contrary to Approved Medical and Professional Standards Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force 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 Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- 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.
- Off label use Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
- 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 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.
- Sex Change Drugs: Drugs for sex change surgery, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with CT Department of Insurance Bulletin IC-37.
- 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

Vision Care that is NOT Covered We will not pay for services incurred for, or in connection with, any of the items below.

- Eye Exams,eyeglass lenses, frames, or contact lenses for members age 19 or older, unless covered by the medical benefits of this plan.
- 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 certificate 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 plan.
- 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 plan.
- 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 plan.
- Cosmetic lenses or options, unless specifically listed in this plan.
- 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.

Dental coverage is NOT provided for:

- Dental care for Members age 19 or older.
- Dental services not listed as covered in this Booklet.
- Services of anesthesiologists, unless required by law.
- Anesthesia Services, except as listed in this booklet and when given with covered complex surgical services and given by a dentist or by an employee of the Dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Oral hygiene instructions.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Enamel microabraision and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- Bacteriologic tests for determination of periodontal disease or pathologic agents
- Cytology sample collection – collection of oral cytology sample via scraping of the oral mucosa.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Occlusal procedures (does not include occlusal guards).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.
- Pin retention is not covered when billed separately from restoration procedure.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Temporary, provisional or interim crown.
- Canal prep & fitting of performed dowel & post.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filing material(s) and the procedures used to prepare and place material(s) in the canals (root).

RIGHT OF RECOVERY

To the extent permissible by law, Anthem shall have a right of recovery against third parties for benefits for Covered Services provided under the terms of this Benefit Program, where the Member has a right of recovery against third parties for the cost of Covered Services. Acceptance of Covered Services will constitute consent by the Member to Anthem's right of recovery. The Member agrees to take all further action to execute and deliver such additional instruments and to take such other action as Anthem shall require to implement this provision. Anthem will have the right to bring suit against such third party in the name of the Member and in its own name as subrogee. The Member shall do nothing to prejudice the rights given to Anthem by this provision without its consent.

If a Member received payment from a third party by suit or settlement for the cost of Covered Services, such Member is obligated to reimburse Anthem less Anthem's pro rata share of the reasonable attorney's fees and cost the Member sustained in obtaining the recovery.

WORKERS' COMPENSATION

To the extent permissible by law, including without limitation section 38a-500 of C.G.S., no benefits shall be provided for Covered Services paid, payable or eligible for coverage under any Workers' Compensation Law, employer's liability or occupational disease law, denied under a managed Workers' Compensation program as Out-of-Network services or which, by law, were rendered without expense to the Member.

To the extent permissible by law, including without limitation section 38a-500 of C.G.S. Anthem shall be entitled to the following:

1) To charge the entity obligated under such law for the dollar value of those benefits to which the Member is entitled.
2) To charge the Member for such dollar value, to the extent that the Member has been paid for the Covered Services.
3) To reduce any sum owing to the Member by the amount that the Member has received payment.
4) To place a lien on any sum owing to the Member for the amount Anthem has paid for Covered Services rendered to the Member, in the event that there is a disputed and/or controverted claim between the Member's employer and the designated Workers' Compensation insurer as to whether or not the Member is entitled to receive Workers' Compensation benefits payments.
5) To recover any such sum owing as described above, in the event that the disputed and/or controverted claim is resolved by monetary settlement to the full extent of such settlement.
6) If a Member is entitled to benefits under Workers' Compensation, employer's liability or occupational disease law, it is necessary to follow all of the guidelines in the Managed Benefits Section in order for this Benefit Program to continue to provide benefits for Covered Services when the Workers' Compensation benefits are exhausted.

AUTOMOBILE INSURANCE

To the extent permissible by law, benefits shall not be provided by this Benefit Program for Covered Services paid, payable or required to be provided as basic reparations benefits under any no-fault or other automobile insurance policy.

Anthem shall be entitled to the following:

1) To charge the insurer obligated under such law for the dollar value of those benefits to which a Member is entitled;
2) To charge the Member for such dollar value, to the extent that the Member has received payment from any and all sources, including but not limited to, first party payment.
3) To reduce any sum owing to the Member by the amount that the Member has received payment from any and all sources, including but not limited to, first party payment.
4) A Member who fails to secure no-fault insurance required by applicable law shall be deemed to be his or her own insurer and Anthem shall reduce his or her benefits for Covered Services by the amount of basic reparations benefits or other benefits provided for injury if such a no-fault policy had been obtained.
5) If a Member is entitled to benefits under a no-fault or other automobile insurance policy, benefits for Covered Services will only be provided when a Member follows all of the guidelines stated in the Managed Benefits Section of the Subscriber Agreement. It is necessary to follow all the guidelines in the Managed Benefits Section in order for Anthem to continue to provide benefits for Covered Services when the no-fault or other automobile insurance policy benefits are exhausted.

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, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, 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 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; 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:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.

3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples, divorce, dissolution of domestic partnership,move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date. When a Member is no longer eligible for coverage in a QHP through the Exchange due to being an overage Dependent, the last day of coverage is the annual renewal date of this Subscriber Agreement on or after the date on which the Member turns age 26.

4. In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5. In the case of a termination for non-payment of the Premium, and the Member is not receiving Advance Payments of Premium Tax Credit, the last day of coverage is the latter of the last day of the grace period or the last day for which Premium payment is made.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Subscriber Agreement, shall become the Subscriber.

Reasonable notice is defined as fourteen days prior to the requested Effective Date of termination.

Guaranteed Renewable

Coverage under this Subscriber Agreement is guaranteed renewable, except as permitted to be terminated, cancelled, 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 Subscriber Agreement by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
2) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Subscriber Agreement; and
3) This Subscriber Agreement 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 Member 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 Subscriber Agreement, 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 Subscriber Agreement 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 61 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Subscriber Agreement.

This Subscriber Agreement 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 Subscriber Agreement. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such

services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

Discontinuation of Coverage

We can refuse to renew your Subscriber Agreement if we decide to discontinue a health coverage product that We offer in the individual market. If we discontinue a health coverage product, we will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal 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 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 Subscriber Agreement 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 Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the latter of the last day of the first month of the 3-month grace period or the last day through which Premium is paid. 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 Subscriber Agreement 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 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Subscriber Agreement has a grace period of 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 Subscriber Agreement will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the Subscriber Agreement is to be terminated. If you do not make the full Premium payment during the grace period, the Subscriber Agreement will be terminated on the latter of the last day of the grace period or the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the grace period.

After Termination

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

CLAIMS PROVISIONS

Anthem reserves the right to review any submitted claims for services and has complete discretion to interpret and apply the terms of the Benefit Program and to determine which services are eligible for reimbursement.

Claim Procedures

Participating Physician, Providers and Hospitals

When you receive Covered Services from a Participating Physician, Provider or Hospital the Physician or Provider shall file the claim with Anthem. Any payment due under this Benefit Program shall be made directly to the Participating Physician, Provider or Hospital.

If further review of a claim is requested the Member should first contact Member Services. If resolution is not met, the Member should follow the guidelines set forth in the Member Appeal Process Section of this Subscriber Agreement.

Benefits for Covered Services will be reimbursed based on the Maximum Allowable Amount for Participating Physicians, Providers or Hospitals.

Maximum Allowed (Allowable) Amount (MAA)

GENERAL

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

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your 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 Benefit Program.

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

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

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

PROVIDER NETWORK STATUS

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

A Participating Provider is a Provider who is in the managed network for this specific 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 Participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

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

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

1) An amount based on Our Non-Participating Provider fee schedule/rate, which we have established in Our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or
4) An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

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

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

Customer Service is also available to assist you in determining this plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate 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).

Your cost share amount and Out-of-Pocket Maximum limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Please see the Schedule of Benefits in this Subscriber Agreement for Your Cost Share responsibilities and limitations, or call Customer Service to learn how this Benefit Program or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Subscriber Agreement, 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 in-network Cost-Sharing amount when you use a Non-Participating Provider.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating 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 a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If we authorize an In-Network Cost-Share amount to apply to a Covered Service received from an Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Payment for Covered Services

Payment by Anthem for Covered Services shall be made directly to the Participating Physician, Participating Provider or Participating Hospital.

For claims filed in paper format, benefits for Covered Services provided to a Member will be processed and paid to the Provider within sixty (60) days of the date the claim is received by Anthem. However, if Anthem requires additional information to process and pay the claim, Anthem will send written notice to the Member or the provider of the need to send in additional information required to process the claim within thirty (30) days after Anthem receives the claim. Anthem will pay the claim not later the thirty (30)

days after Anthem receives the information requested to process and pay the claim under the contract. Before the end of the initial sixty (60) day period, Anthem will send the Member written notice of the reason(s) for the delay.

For claims filed in electronic format, benefits for Covered Services provided to a Member will be processed and paid to the Provider within twenty (20) days of the date the claim is received by Anthem. However, if Anthem requires additional information to process and pay the claim, Anthem will send written notice to the Member or the Provider of the need to send in additional information required to process the claim within ten (10) days after Anthem receives the claim. Anthem will pay the claim not later the ten (10) days after Anthem receives the information requested to process and pay the claim under the contract. Before the end of the initial twenty (20) day period, Anthem will send the Member written notice of the reason(s) for the delay.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced 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.

Claim Overpayments

When Anthem has made payments for Covered Services either in error or in excess of the maximum amount of payment necessary to satisfy the provisions of this Benefit Program, Anthem has the right to recover these payments from one or more of the following as may be appropriate. Anthem will not attempt to recover from any Member or Provider overpayments not made to or held by such Member or Provider. Overpayments may be recovered from:

- Any person to or for whom such payments were made;
- Any insurance companies; or
- Any other organizations.

Anthem's right to recover may include subtracting from future benefits payments the amount Anthem has paid in error or in excess. The Subscriber personally and on behalf of his or her Dependents will, upon request, execute and deliver such documents as may be required and do whatever is necessary to secure Anthem's right to recover any erroneous or excess payments.

Under BlueCard, recoveries made from a Blue Cross and/or Blue Shield plan in the BlueCard program or from Participating Providers of a Blue Cross and/or Blue Shield plan in the BlueCard program can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/Hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Blue Cross and/or Blue Shield plan will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard policies, which generally require correction on a claim-by-claim or prospective basis.

Claim Denials

If benefits are denied, in whole or in part, Anthem will send the Member a written notice within the established time periods described in the section Payment for Covered Services. The Member or the Member's duly authorized representative may appeal the denial as described in the Member Appeal Process section below. The adverse determination notice will include the reason(s) for the denial, reference to the Benefit Program provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA section 502(a).

If the denial involves a utilization review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

Deductible Calculation

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

The In-Network and Out-of-Network Deductibles are separate and do not apply toward each other.

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

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

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

Out-of-Pocket Limit Calculation

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

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

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

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

PREMIUMS

The amount, time and manner of payment of Premiums shall be determined by Anthem and shall be subject to the approval of the State of Connecticut Insurance Department.

(1) All Premiums shall be due and payable in full and in advance for the period in which this Benefit Program provides benefits.

(2) Failure of the Subscriber to remit Premium due shall void the eligibility of the Subscriber and his or her Dependents to receive benefits covered under this Benefit Program. In such cases, the Subscriber will become financially responsible for any services rendered as of the last day Premium has been received by Anthem.

(3) The rates are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Subscriber Agreement may change subject to, and as permitted by, applicable law. In the event of any change in Premium, the Subscriber will be given notice at least 30 days prior to such change. Payment of the Premium by the Subscriber of contributions shall serve as notice of the Subscriber's acceptance of the change.

(4) Anthem shall not routinely issue a Premium refund in amounts of less than one dollar.

(5) Anthem may apply refunds and credits for the following reasons:

a) The death of the Subscriber or his or her Dependent;

b) The Subscriber has prepaid beyond the cancellation date;

c) The Premium has been prepaid beyond the cancellation date; or

d) Overpayments.

(6) In no event will a refund or credit be made for more than a period of 12 months from the date of the qualifying event.

(7) Refunds and credits will not be pro-rated for less than 61 days.

(8) 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.

(9) In the event that Anthem does not receive the required Premium for the initial 61 days following birth of a newborn as outlined above, Anthem may (i) refuse to allow the newborn to be added to this Benefit Program following the 61 day period after the date of birth; or (ii) file a court action against the Subscriber and/or the spouse (if they are married) for the additional Premium if required for the first 61 days after birth.

(10) In the event that Anthem does not receive the required Premium for the initial 61 days following birth of a newborn as outlined above, Anthem may (i) refuse to allow the newborn to be added to this Subscriber Agreement following the 61 day period after the date of birth (Newborns of a Dependent are not covered, see "Newborn of Enrolled Dependent" in the "Eligibility" section of this Subscriber Agreement); or (ii) file a court action against the Subscriber and/or the spouse (if they are married) for the additional Premium if required for the first 61 days after birth.

Note: Anthem will not deny any claims for Covered Services rightfully incurred and/or paid for the newborn child during the first 61 days following birth, including claims for Covered Services received in its own right that exceed the mothers maternity benefit.

MEMBER APPEAL PROCESS

Rights Available to Members

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which this decision was based. If you prefer, any other person you choose may ask for this information. We will send this information within five business days after receiving your request. We will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or health care service for which you received emergency services but haven't been discharged from a facility; or
- A denial of coverage based on a decision that the recommended or requested health care service or treatment is experimental or investigational and your treating provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

We will send the information by fax, electronic means or any other fast method.

If you don't agree with our coverage decision, you have the right to ask for a grievance (also known as an appeal). The review of your grievance may change our previous coverage decision.

Unless your health benefit plan documents state otherwise, you must ask for a grievance within 180 calendar days from the date you get this letter. You, your provider, or any other person you choose, may ask for a grievance on your behalf. A person of your choice may also help you during the grievance process. You need to let us know, in writing, if you want someone to represent or help you.

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing a grievance.

Consumer Affairs Division of the Connecticut Insurance Department

Address: P.O. Box 816
Hartford, CT 06142-0816
Phone: 860-297-3900 (local)
800-203-3447 (toll-free)
Email: cid.ca@ct.gov

Connecticut Office of the Health Care Advocate

Address: P.O. Box 1543
Hartford, CT 06144
Phone: 866-466-4446 (toll-free)
Email: Healthcare.advocate@ct.gov

How do I ask for an expedited grievance?

An expedited (fast) grievance is available if you have not had services and the time frame of a standard grievance review would:

- Seriously jeopardize (harm) your life or health; or
- Jeopardize your ability to regain maximum function.

An expedited grievance is also available for :

- Substance use disorder or co-occurring mental health disorder; or

- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

You, your doctor or any person you choose, may ask for an expedited grievance in writing or by phone. In your request, please let us know that you are asking for an expedited grievance. Include any additional information you have that supports the request.

In writing: Send a written request to Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201.

In writing for Mental Health and Substance Abuse: Send a written request to Grievances and Appeals, P.O. Box 2100 North Haven, CT 06473-4201.

By phone: Call customer service at the phone number on your member ID card.

Generally, we will let you know our decision within 72 hours of receiving a request for an expedited grievance. However, we will let you know our decision within 24 hours of receiving an expedited grievance, unless you or the person you choose to act on your behalf or help you, fails to give us information needed to make a coverage decision, for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

We will let you know our decision by phone, fax, or any other available means.

You, your doctor or any person you choose may ask for an expedited external review with the Connecticut Insurance Department instead of, or at the same time as, asking for an expedited grievance with us if:

- You have a medical condition for which the time period for completing an expedited internal review would seriously jeopardize your health or your ability to regain maximum function;
- The decision concerns an admission, availability of care, continued stay or health care services for which you received emergency services but have not been discharged; or
- Coverage is denied because the service or treatment is experimental or investigational and your treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly started and you have also filed a request for an expedited internal review.

Your request must be sent in writing to the Connecticut Insurance Department.

In writing: Send a written request to the Connecticut Insurance Department, Attention External Review, P.O. Box 816, Hartford, CT 06142-0816. If you prefer, the request can be sent by overnight mail to 153 Market Street, 7th Floor, Hartford, CT 06103. An External Review Guide and application are available on the Department's web site, www.ct.gov/cid.

If you ask for an expedited external review with the Connecticut Insurance Department at the same time as an expedited grievance with us, the Independent Review Organization (IRO) assigned to your review by the Insurance Commissioner will decide if you must finish the expedited internal review with us before moving forward with the expedited external review.

How do I ask for a standard grievance?

You may ask for a standard grievance (a grievance that is not expedited) for a coverage decision you don't agree with. You can also ask for a standard grievance for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let us know that you are asking for a grievance. Include any additional information you have to support your request.

In writing: Send a written request to Grievances and Appeals, P.O. Box 1038, North Haven, CT 06473-4201.

In writing for Mental Health and Substance Abuse: Send a written request to Grievances and Appeals, P.O. Box 2100 North Haven, CT 06473-4201.

Unless your health benefit plan documents state otherwise, we will respond to a grievance for a medical necessity decision within 30 calendar days from the date we get the request. We will respond to a grievance not based on medical necessity within 20 business days from the date we get the request. Our response will be in writing.

Please refer to the Section "Prescription Drug List" for the process for submitting an exception request for Drugs not on the Prescription Drug List.

What should my grievance include?

Include, if available, the following information with your grievance:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree; and
- The specific reason(s) why you don't agree with the decision.

You can, and we encourage you to, give us written comments, documents and other relevant information with your grievance. This may include narratives, letters and treatment notes. You can ask for this information from your health care provider.

How will my grievance be handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications as specified in the "Definitions" section of this Subscriber Agreement. This Bulletin can be found at www.ct.gov/cid. All relevant information given to us by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If your grievance involves a substance use or mental health disorder, we will also use the criteria defined in Bulletin HC-92 to review your request.

If your grievance is not based on medical necessity, we will send it for appropriate administrative review.

We may reach out to any providers who may have additional information to support your grievance. The reviewers won't have been involved in the initial decision. They also won't be a subordinate (in a lower position) of the person who made the initial decision.

Before issuing a decision on a grievance of an adverse coverage decision based on medical necessity, we will give you, free of charge, any new or additional evidence relied upon or scientific or clinical rationale. We will give you this information in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

If I don't agree with the decision on my grievance, what other rights do I have?

If we deny your grievance, we will give you information about the external review process administered through the Connecticut Insurance Department. We will also give you an external review application. You, or any person you choose, must send a request for an external review to the State of Connecticut Insurance Department within 120 days from the date you get our response to your grievance.

If we don’t respond to a first level grievance involving medical necessity within the required timeframe, you can ask for an external review without having to exhaust your grievance rights with us.

Look at your health benefit plan documents for more details about the grievance process. You can also call customer service at the phone number on your member ID card.

PLAN INFORMATION PRACTICES NOTICE

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

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

NOTICE

Any notice given by Anthem to a Subscriber shall be sufficient if mailed to the Subscriber at his or her address as it appears on the records of Anthem. Notice given to Anthem must be sent to Anthem's address as shown in this Subscriber Agreement. Anthem, or a Member, may by written notice, indicate a new address for giving notice.

MISCELLANEOUS PROVISIONS

Entire Subscriber Agreement

This Subscriber Agreement, including the endorsements and the attached papers, if any, make up the entire contract of coverage. We have discretionary authority to determine your eligibility for benefits and to construe the provisions of this Subscriber Agreement.

The membership enrollment application and rate page are incorporated by reference herein.

A Member shall complete and submit to Anthem such applications or other forms or statements as Anthem may reasonably request. A Member warrants that all information contained therein shall be true, correct, and complete to the best of the Member's knowledge and belief and the Member accepts that all right to benefits under this Benefit Program are conditional upon said warranties. No statement by the Member in his or her enrollment application shall void this Subscriber Agreement or be used in any legal proceeding unless such enrollment application or an exact copy thereof is included in or attached to the Subscriber Agreement.

Time Limit on Certain Defenses

This Subscriber Agreement shall be incontestable, except for nonpayment of Premium, after it has been in force for two years from its date of issue.

Anthem as the Insurance Carrier

Anthem does not furnish Covered Services. Anthem makes payment of the Maximum Allowed Amount for Covered Services received by Members. Anthem is not liable for any act or omission of any Physician, Provider or Hospital. Anthem has no responsibility for a Physician's, Provider's or Hospital's failure or refusal to render Covered Services to a Member.

Anthem's sole obligation is to provide the benefits described in the Subscriber Agreement. No action at law based upon or arising out of the Physician-patient, Provider-patient or Hospital-patient relationship may be maintained against Anthem.

The use or non-use of an adjective such as "participating" or "non-participating" in modifying the term "Physician," "Provider" or "Hospital" is not a statement as to the ability of the Physician, Provider or Hospital.

Disclosure

The Member hereby expressly acknowledges its understanding that the Subscriber Agreement constitutes a contract solely between the Member and Anthem Blue Cross and Blue Shield, 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 Association") permitting Anthem to use the Blue Cross and Blue Shield service marks in the State of Connecticut, and that Anthem is not contracting as an agent of the Association. The Member further acknowledges and agrees that he or she has not entered in this Subscriber Agreement based upon representations by any person other than Anthem and that no person, entity or organization other than Anthem shall be held accountable or liable to the Member for any of Anthem's obligations to the Member created under the Subscriber Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Subscriber Agreement.

Authority for Discretionary Decisions

Anthem, or anyone acting on its behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem, or anyone acting on its behalf, has complete discretion to determine the administration of the Member's benefits. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary,

Investigational/Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with its Maximum Allowed Amount. However, a Member may utilize all applicable Member Appeal procedures.

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

Release of Records

By your enrollment application, you have agreed to allow all Providers to give us needed information about the care they provide to you to the extent permitted by law.

Clerical Errors

Clerical errors made in connection with the Benefit Program, whether by Anthem, or the Member will not terminate coverage that would otherwise have been effective; or continue coverage that would otherwise have ceased or should not have been in effect.

Assigning Coverage

A Member may not assign this Benefit Program or any of the Member's rights, benefits or obligations under this Subscriber Agreement to any other person or entity except with the prior written consent of Anthem, which consent may be conditioned by or withheld by Anthem in its sole discretion. Any attempted assignment by a Member in violation of this provision shall not impose any obligation upon Anthem to honor or give effect to such assignment and shall constitute grounds for cancellation of this Benefit Program, effective as of the date to which Premiums have been paid.

Notwithstanding the terms of any provision regarding the payment of benefits payable for a Covered Service, a Member may assign the benefits to a dentist or oral surgeon, who performs such services, in accordance with the Connecticut Law concerning Assignment of Benefits to a Dentist or Oral Surgeon.

Notice of Claim

Anthem will not be liable under the Subscriber Agreement unless proper notice is furnished to Anthem that Covered Services have been rendered to a Member. Written notice must be given within 60 days after completion of the Covered Services. The notice must include the data necessary for Anthem to determine benefits. An expense will be considered incurred on the date the service or supply was received.

Failure to give notice to Anthem within the time specified will not reduce any benefit if it is shown to our satisfaction that the notice was given as soon as reasonably possible, but in no event will Anthem be required to accept notice more than two years after Covered Services are received.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. Claim forms will be furnished to you if needed within 15 days after this written notice. If you do not receive the claims 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.

Legal Actions

No legal action may be taken to recover benefits within 60 days after notice of claim has been given as specified above, nor may any action be brought after three years from the date Covered Services are received. No liability shall be imposed upon Anthem other than for benefits provided herein.

Identification Cards

Anthem will provide the Subscriber with Identification Cards.

Changes to the Subscriber Agreement

This Subscriber Agreement shall remain in effect unless amended, terminated, rescinded, suspended or cancelled as described herein. Anthem may amend the Subscriber Agreement with approval from the State of Connecticut Department of Insurance. The Effective Date of such changes shall be designated by Anthem, and notification to Subscribers will be provided by Anthem.

No agent or representative of Anthem, other than an officer of Anthem, is authorized to change this Benefit Program or to waive any of its provisions. Any such changes or waivers must be in writing.

Anthem has the right to develop medical and managed care policies and procedures and to amend such policies and procedures from time to time. The effective date of such changes shall be designated by Anthem.

Compliance with Laws

If State of Connecticut or federal laws that affect the meaning of any term or provision contained in this Subscriber Agreement are revised, the provisions of this Subscriber Agreement will automatically change to comply with those laws as of their effective dates. Any provision that does not conform with applicable federal laws or the relevant laws of the state of Connecticut will not be rendered invalid, but will be construed and applied as if it were in full compliance.

Time Periods

When the time of day is important for benefits or determining when coverage starts and ends, a day begins at 12:01 a.m. and ends at 12:00 p.m. eastern standard time.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-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 In-Network Provider or for any injuries suffered by you while receiving care from any In-Network Provider's Facilities.

Your In-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.

Payment Innovation Programs

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

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

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

PLAN DESCRIPTION INFORMATION

Participating Provider Reimbursement

Reimbursement methodologies include but are not limited to the following:

- Participating Providers are paid according to a fee-schedule for services rendered, which is an amount these Providers accept as compensation in full for Covered Services. Individual Providers can contract through a corporate entity in an assumed risk-sharing position with the Anthem for services rendered by professional Providers whom the entity represents.
- Global Case Rate: This is an amount for pre-procedure, procedure and post-procedure covered benefits which are all related to the same Covered Service.
- Global Capitation: This involves setting health care budget for each Member of a health care delivery system. The delivery system tries to perform at or under the amount. If successful, the delivery system shares in the success. If it fails, the delivery system is accountable for amounts over budget on an annual basis.

Participating Institutional Providers

Institutional Providers include, but are not limited to: general Hospitals, rehabilitation Hospitals, ambulatory surgery centers, and behavioral health facilities.

Reimbursement methodologies include but are not limited to the following:

- Billed charges;
- Discounts off billed charges;
- Per day payments;
- Per episode-of-care payments; and
- Fixed payment per Member per month.

Member Satisfaction Information

PPO Satisfaction:

Overall, 85.2% of Anthem members have positive rating regarding their health plan. To reach Anthem during normal business hours (8:00 a.m.-5:00 p.m.) please call the telephone number indicated on the back of your Identification Card. After normal business hours: Members may call the same telephone number, and receive information via an automated telephone system. A Member may also receive information via Anthem Blue Cross Blue Shield web site at www.Anthem.com. This web site is available twenty- four hours every day, seven days a week.

Medical Loss Ratio

For insurance entities, the term “medical loss ratio“ refers to the ratio of incurred claims to earned Premium for a prior Calendar Year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2014 Anthem’s Medical Loss Ratio for state law purposes was 72.8% for HMO plans and 90.5% for PPO/Indemnity plans. For 2014 Anthem’s MLR for federal law purposes was 84.7% for Individual plans.

Utilization Review Determinations

During **2014** Anthem’s utilization review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for pre-admission review and admission review:	76,909
Number of pre-admission and admission review denials:	1424

Number of appeals of denials:	359
Number of denials reversed or negotiated upon appeal:	115

To reach Anthem's utilization review department, call (in-state) 1-800-238-2227 or (out-of-state) 1-800-248-2227. The telephone system is capable of accepting and recording calls received after hours, on weekends, and holidays. Callers are provided with instructions and may leave a recorded message with detailed information. Calls are returned during normal business hours no later than one (1) business day from the date on which the call was received or the details necessary to respond are received from the caller.

Member Notification

When a Primary Care Physician leaves the network, Anthem is responsible for informing the Member in writing within 30 days of the date of the Primary Care Physician's departure.

DEFINITIONS

ACUTE PSYCHIATRIC CARE: The term Acute Psychiatric Care means psychotherapy provided on an individual or group basis by a Physician or health care team under the supervision of a Physician.

ADMISSION: The term Admission means the period from the date the Member enters the Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility, Hospice or other Inpatient Facility as an Inpatient until the date of discharge. When counting days of Inpatient services, the date of entry and date of discharge are combined to count together as one day.

Elective Admission: The term Elective Admission means an Inpatient Admission which is Medically Necessary and scheduled in advance where the Member does not require immediate medical treatment to prevent death, disability or serious impairment of bodily part or function.

ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT (APTC): The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

AMERICAN INDIAN: The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

APPLIANCE(S): The term Appliance(s) means leg, arm, back or neck braces, or artificial legs, arms or eyes, and any prosthesis with supports, including replacement if a Member's physical condition changes.

AUTHORIZE: The term Authorize (Authorization) means that approval has been obtained from Anthem for the Emergency Admission of a Member to a Hospital, Skilled Nursing Facility, Substance Abuse Treatment Facility, Residential Treatment Facility or Hospice, when required under the terms of this Benefit Program.

BENEFIT PROGRAM: The term Benefit Program means the program of health care benefits that is identified on the cover page of the Subscriber Agreement and described herein.

BENEFIT YEAR: The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

BRAND NAME DRUG: The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

CALENDAR YEAR: The term Calendar Year means a period beginning 12:01 a.m. on January 1 and ending midnight on December 31 of the same year.

CASE MANAGEMENT: The term Case Management means the process of evaluating and arranging for Medically Necessary treatment for patients, identified through the use of one or more managed care programs.

CLINICAL PEER- The term Clinical Peer means a physician or other health care professional who:

1) holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
2) for an urgent care review concerning:
   a. a child or adolescent substance use disorder or a child or adolescent mental disorder, holds;
      - a national board certification in child and adolescent psychiatry; or
      - a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or (ii)
   b. an adult substance use disorder or an adult mental disorder, holds;
      - a national board certification in psychiatry; or

- a doctoral level psychology degree with and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

A review for a substance use disorder with or without a co-occurring mental disorder, or for a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting are considered an urgent care request.

COINSURANCE: The term Coinsurance means a fixed percentage of the Maximum Allowable Amount for Covered Services which the Member is required to pay as specified in the Schedule of Benefits.

COPAYMENT: The term Copayment means 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.

COST-SHARE: The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance and/or Deductibles.

COVERED SERVICE(S): The term Covered Service means services, supplies or treatment as described in this Subscriber Agreement. To be a Covered Service, the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Subscriber Agreement;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Subscriber Agreement is in force;
- Not Experimental or Investigational or otherwise excluded or limited by the Subscriber Agreement;
- Authorized in advance by Anthem if such preauthorization is required under the Subscriber Agreement.

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

- Assistance with walking, bathing, or dressing;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Oral hygiene;
- Ordinary skin and nail care;
- Catheter care;
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets and supervision over medical equipment or exercises; and
- Self-administration of oral medications not requiring constant attention of trained medical personnel.

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

DAY/NIGHT VISIT: The term Day/Night Visit means continuous treatment consisting of not less than 4 hours and not more than 12 hours in any 24 hour period when received in a General or Specialty Hospital or in a Substance Abuse Treatment Facility.

DEDUCTIBLE: The term Deductible means the amount You owe for health care services Your health insurance or plan covers before Your health insurance or plan begins to pay. For example, if Your

deductible is $1000, Your plan won't pay anything until You've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

DENTALLY NECESSARY ORTHODONTIC CARE: A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the "Dental Care (Pediatric)" section for more information.

DEPENDENT: The term Dependent means a Subscriber's lawful spouse under a legally valid existing marriage and any children who meet the eligibility requirements set forth in the Eligibility Section of this Subscriber Agreement.

DOMESTIC PARTNER: The term Domestic Partner refers to two individuals, of the same sex or opposite sex, that have been each other's sole domestic partner for 12 months or more; are mentally competent; at least 18 years old; who are not related in any way (including by blood or adoption) that would prohibit marriage under state law; not married to or separated from anyone else; and are financially interdependent.

DURABLE MEDICAL EQUIPMENT (DME): The term Durable Medical Equipment (DME) means 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: The term Effective Date means the date a Subscriber and his or her Dependents, if any, are accepted by Anthem and eligible to receive benefits for Covered Services under this Benefit Program.

EXPEDITED GRIEVANCE- The term Expedited Grievance means a coverage review request for: (1) Urgent care which is a request for a health care service or course of treatment for which the time period for making a non-urgent care request determination (A) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (B) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested; (2) for a substance use disorder or co-occurring mental health disorder or Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep a covered person from requiring an inpatient setting in connection with a mental health disorder.

EXPERIMENTAL OR INVESTIGATIONAL: The term Experimental or Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines in its sole discretion to be Experimental or Investigational.

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

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

   1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or
   2. Has been determined by the FDA to be contraindicated for the specific use; or
   3. Is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
   4. Is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function; or
   5. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity or efficacy of

the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

B. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem will consider the information described in subsection C. and assess the following:
    1. Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;
    2. Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
    3. Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;
    4. Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population of whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

C. The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A. and B. may include one or more items from the following list which is not all inclusive:
    1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
    2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
    3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    4. Documents of an IRB or other similar body performing substantially the same function; or
    5. Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    6. The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
    7. Medical records; or
    8. The opinions of consulting providers and other experts in the field.

D. Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.
    - Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III Clinical Trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.
    - In addition, services and supplies for Routine Patient Care Costs in connection with a Clinical Trial will not be considered Experimental.

FORMULARY: The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This formulary contains a limited number of prescription drugs, and may be different than the formulary for other Anthem products. Generally, it includes select generic drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by

Anthem. We may add or delete prescription drugs from this formulary from time to time. A description of the prescription drugs that are listed on this formulary is available upon request and at www.anthem.com

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

HABILITATIVE/HABILITATION SERVICES: 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.

HOSPICE: The term Hospice means a facility, organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

HOSPICE CARE: A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

HOSPITAL: The term Hospital means an institution which provides 24 hour continuous services to confined patients and whose chief function is to provide diagnosis and therapeutic facilities for the surgical and medical diagnosis, treatment or care of injured or sick persons. A professional staff of licensed Physicians and surgeons must provide or supervise the services. The institution must provide General Hospital and major surgical facilities and services or specialty services. The following shall not be considered a Hospital:

- A convalescent or extended care unit within or affiliated with the Hospital;
- A non-Hospital based clinic;
- A nursing, rest or convalescent home, or extended care facility;
- An institution operated mainly for care of the aged;
- A health resort, spa or sanitarium; or
- Any facility not having appropriate state licensure and not accredited as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), except for a Hospital located outside the United States.

1) **General Hospital**: The term General Hospital means a Hospital which is licensed as such by the State of Connecticut and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

If out-of-state, a General Hospital must have equivalent licensure and accreditation.

2) **Specialty Hospital**: The term Specialty Hospital means a Hospital which is not a General Hospital but which is licensed by the State of Connecticut as a certain type of Specialty Hospital and has appropriate accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

If out-of-state, a Specialty Hospital must have equivalent licensure and accreditation.

3) **Participating Hospital:** The term Participating Hospital means a Hospital designated and accepted as a Participating Hospital by Anthem to provide Covered Services to Members under the terms of the Subscriber Agreement.
4) **Non-Participating Hospital:** The term Non-Participating Hospital means any appropriately licensed Hospital which is not a Participating Hospital under the terms of the Subscriber Agreement.

5) **Mobile Field Hospital:** The term Mobile Field Hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

IDENTIFICATION CARD: The term Identification Card means a card issued by Anthem to a Subscriber for identification purposes which must be shown by the Member to obtain Covered Services.

IN-NETWORK: The term In-Network means that Covered Services are obtained from any Participating Physicians, Participating Hospital or Participating Provider.

INPATIENT: The term Inpatient means a Member who occupies a bed in a Hospital or other 24 hour care facility, receives board as well as diagnosis, care or treatment and is counted as an Inpatient at the time of a Hospital or 24 hour care facility census.

INPATIENT FACILITY: The term Inpatient Facility means a facility other than a Hospital that provides board as well as diagnosis, care or treatment on a 24 hour basis to patients, such as, a Skilled Nursing Facility, Hospice, Substance Abuse Treatment Facility, Sub-acute Care Facility and Residential Treatment Facility.

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

MEDICAL EMERGENCY: The term Medical Emergency means the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms or final diagnosis of sufficient severity that a Member reasonably believes that emergency medical treatment is needed.

MEDICALLY NECESSARY (MEDICALLY NECESSARY CARE, MEDICAL NECESSITY): The terms Medically Necessary (Medical Necessary Care, Medical Necessity) mean health care services that physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
3. Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purpose of this subsection, "generally accepted standards of medical practice" means standards that based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

MEDICARE: The term Medicare means Title XVIII of the Social Security Act of 1965, as amended.

MEMBER: The term Member means either a Subscriber or Dependent enrolled in this Benefit Program and eligible for benefits for Covered Services under this Benefit Program.

MENTAL HEALTH AND SUBSTANCE ABUSE The terms Mental Health and Substance Abuse means a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

MINIMUM ESSENTIAL COVERAGE - The term means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within

a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

NON-PARTICIPATING HOSPITAL: The term Non-Participating Hospital means any appropriately licensed Hospital which is not a Participating Hospital under the terms of this Benefit Program.

NON-PARTICIPATING PHYSICIAN: The term Non-Participating Physician means any appropriately licensed physician who is not a Participating Physician under the terms of this Benefit Program.

NON-PARTICIPATING PROVIDER: The term Non-Participating Provider means any appropriately licensed health care professional or facility who is not a Participating Provider under the terms of this Benefit Program.

OUT-OF-NETWORK The term Out-of-Network means that Covered Services are obtained from any Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider. Non-Participating Physician, Non-Participating Hospital or Non-Participating Provider also includes Providers who have not contracted or affiliated with Anthem's designated Subcontractor(s) for the service they perform under this Subscriber Agreement.

OUT-OF-POCKET LIMIT(S): The term Out- of- Pocket Limit(s) means A specified dollar amount of expense incurred for Covered Services in a Calendar Year as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Subscriber Agreement.

OUTPATIENT: The term Outpatient means that the Member receives services in a Hospital emergency room, Physician's office, or ambulatory surgical facility and leaves in less than 24 hours.

PARTIAL HOSPITALIZATION: The term Partial Hospitalization means continuous treatment in a General Hospital, Specialty Hospital or Residential Treatment Facility consisting of not less than 4 hours and not more than 12 hours in any 24 hour period.

PARTICIPATING HOSPITAL*:* The term Participating Hospital means a Hospital designated and accepted as a Participating Hospital by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

PARTICIPATING PHARMACY: The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

PARTICIPATING PHYSICIAN: The term Participating Physician means any appropriately licensed physician designated and accepted as a participating physician by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

PARTICIPATING PROVIDER: The term Participating Provider means any appropriately licensed health care professional or facility designated and accepted as a Participating Provider by Anthem to provide Covered Services to Members under the terms of this Benefit Program.

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

PHARMACY AND THERAPEUTICS (P&T) PROCESS: The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem 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.

PHYSICIAN: See definition of Provider.

PLAN YEAR: The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

PREMIUM: The term Premium means the amount charged by Anthem to provide benefits for Covered Services under this Benefit Program.

PRESCRIPTION DRUG (DRUG): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes insulin, diabetic supplies, and syringes.

PRIMARY CARE PHYSICIAN: The term Primary Care Physician means a Participating Physician or an Advance Practice Registered Nurse who may be selected by the Member from the list provided by Anthem of internal medicine, family practice, and pediatric Participating Physicians or as may be permitted by applicable law. The Primary Care Physician renders general medical Covered Services, coordinates the Member's overall medical care, prescribes services or supplies to other physicians or Providers, and keeps and maintains the Member's medical records.

PRIOR AUTHORIZATION (PRIOR AUTHORIZED): The term Prior Authorization means that prior approval has been obtained from Anthem, which enables a Member to receive benefits for certain Covered Services.

PROOF: The term Proof means any information that may be required by Anthem in order to satisfactorily determine a Member's eligibility or compliance with any provision of this Benefit Program.

PROSTHETIC DEVICE: The term Prosthetic Device means any device which replaces all or part of a body organ (including contiguous tissues), or replaces all or part of the function of a permanently inoperative, absent, or malfunctioning part of the body.

PROVIDER: The term Provider means any appropriately licensed or certified health care professional or facility providing health care services or supplies to Members.

> **Participating Provider**: The term Participating Provider means any appropriately licensed or certified health care professional or facility designated and accepted as a Participating Provider by Anthem to provide Covered Services to Members.
>
> **Non-Participating Provider**: The term Non-Participating Provider means any appropriately licensed or certified health care professional or facility which is not a Participating Provider.

QUALIFIED HEALTH PLAN or QHP: The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

QUALIFIED HEALTH PLAN ISSUER OR QHP ISSUER: The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

QUALIFIED INDIVIDUAL: The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

RESIDENTIAL TREATMENT FACILITY: The term Residential Treatment Facility means a treatment center which provides residential care and treatment for emotionally disturbed individuals, is licensed by the Department of Children and Families (DCF), and is accredited by the Council on Accreditation or The Joint Commission on the Accreditation of Health Care Organizations as a Residential Treatment Facility.

ROUTINE PATIENT CARE COSTS: The term Routine Patient Care Costs means: Costs for Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in

conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Member during the course of treatment in a Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law. Hospitalization shall for Routine Patient Care Costs include treatment at an Non-Participating facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Non-Participating Hospitalization will be rendered at no greater cost-share to the member than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

1) The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;
2) The cost of a non health care service that a Member may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;
3) Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;
4) Costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;
5) Costs that would not be covered under this Benefit Program for non-investigational treatments, including items excluded from coverage under the Benefit Program; and
6) Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the member or any family member or companion.

SELF-ADMINISTERED DRUGS: The term Self-Administered Drugs means drugs that are administered which do not require a medical professional to administer.

SKILLED NURSING FACILITY: The term Skilled Nursing Facility means any institution that:

1) Accepts and charges for patients on an Inpatient basis;
2) Is primarily engaged in providing skilled nursing care, rehabilitative and related services to patients requiring medical and skilled nursing care;
3) Is under the supervision of a licensed Physician;
4) Provides 24 hour a day nursing service under the supervision of a registered nurse; and
5) Is not a place primarily for the treatment of nervous-mental disorders, pulmonary tuberculosis, a place of rest, Custodial Care or acute Inpatient level of care.

SPECIALIZED FORMULA: The term Specialized Formula means a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

SPECIALTY DRUGS: The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

STATE: The term State means each of the 50 States and the District of Columbia.

SUBCONTRACTOR: The term Subcontractor means an entity with which Anthem may subcontract particular services to such as organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem's behalf.

SUBSCRIBER: The term Subscriber means a person who is eligible for Covered Services, has enrolled in this Benefit Program and for whom Anthem BCBCS has accepted the appropriate Premium.

SUBSCRIBER AGREEMENT: The term Subscriber Agreement means this document, which describes the rights, benefits, terms, conditions and limitations of the coverage available to Subscribers and eligible Dependents, including the Schedule of Benefits, the membership application, health statement, rate page and any riders and amendments thereto.

SUBSTANCE ABUSE TREATMENT FACILITY: The term Substance Abuse Treatment Facility means a facility which is established primarily to provide 24 hour Inpatient treatment of substance abuse and licensed for such care by the State of Connecticut Department of Public Health and Addiction Services.

TAX DEPENDENT: The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

TAX FILER: The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

1. To file an income tax return for the Benefit Year
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

TIER ONE DRUGS: This tier includes low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

TIER TWO DRUGS: This tier includes preferred Drugs considered single source Brand Drugs, or multi-source Brand Drugs.

TIER THREE DRUGS: This tier includes Drugs considered single source Brand Drugs, or multi-source Brand Drugs.

TIER FOUR DRUGS: This tier contains high cost Drugs. This includes Drugs considered single source Brand Drugs, and multi-source Brand Drugs.

URGENT CARE: The term Urgent Care means care for an illness or injury which is not a Medical Emergency but requires immediate medical attention.

URGENT CARE FACILITY: The term Urgent Care Facility means a Participating Provider from whom Urgent Care services may be obtained.