Anthem Gold Pathway X PPO 750/15%

HIOS ID **33670NV1050011-01**

SUMMARY OF BENEFITS

This chart is an overview of Your benefits for Covered Services, which are listed in detail in the "Member Benefits (What is Covered)" section. A list of services that are not covered can be found in the "General Exclusions" section.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Certificate will allow for a Covered Service. The Deductible applies to all Covered Services with a Co-insurance, including 0% Co-insurance, except for In-Network Preventive Care Services required by law. For a detailed explanation of how Your Deductibles and Out-of-Pocket Annual Maximums are calculated, see the "How Your Plan Works" section.

Plan Features

Deductible	In-Network Member Pays	Out-of-Network Member Pays
Individual	$750	$1,250
Family	$1,500	$2,500

The individual Deductible applies to each covered family Member. No one person can contribute more than their individual Deductible amount.

Once two or more covered family Members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Benefit Period.

Co-insurance	In-Network Member Pays	Out-of-Network Member Pays
Co-insurance Percentage (unless otherwise specified)	15% Co-insurance	50% Co-insurance plus all charges in excess of the Maximum Allowed Amount

Out-of-Pocket Annual Maximum	In-Network Member Pays	Out-of-Network Member Pays
Individual	$6,850	$17,125
Family Includes Deductible, Copayments and Co-insurance	$13,700	$34,250

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

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

Anthem can help You find an In-Network Provider specific to Your Policy by calling the number on the back of Your Identification Card.

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Ambulance Services		
Emergency (Ground, air and water services) Care is covered In-Network and Out-of-Network. Benefits are paid for Medically Necessary ground, air or water ambulance transportation.	$0 Copayment 15% Co-insurance	$0 Copayment 15% Co-insurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is Precertified by Us for use. Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute facility to another, must be approved through precertification.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Autism Services Applied Behavior Analysis benefit maximum per Benefit Period: 500 hourly sessions. Benefits are provided to covered Members under 18 years of age or, if enrolled in high school, until the Member reaches 22 years of age. See Outpatient Therapy Services for additional therapy services.	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Pediatric Dental Services are described below.	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Diabetic Medical Equipment & Supplies	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Advanced Imaging Services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Doctor Office Visits		
Primary Care Physician (PCP) Copayment applies to PCP office visit charge, consultations, Online Visits and Retail Health Clinic.	$25 Copayment 0% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Specialty Care Physician (SCP) and Specialists	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Inpatient/Outpatient	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Other Office Services Telemedicine	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Durable Medical Equipment (medical supplies and equipment) Includes diabetic supplies and equipment, medical supplies, Durable Medical Equipment, oxygen and equipment, Orthopedic Appliances, prosthetic devices and other appliances. Hearing aids: Limited to a single purchase. Repairs and replacement limited to once every 3 years.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Emergency room visits Care is covered In-Network and Out-of-Network. Copayment is waived if admitted.	After the Deductible has been satisfied: $250 Copayment 15% Co-insurance	After the Deductible has been satisfied: $250 Copayment 15% Co-insurance
Enteral Formula and Special Foods Special food products that are prescribed or ordered by a Physician as Medically Necessary for certain inherited metabolic disorders are allowed.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Home Health Care Limited to a maximum of 30 visits per Member, per Benefit Period combined with Private Duty Nursing Services.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Hospice Care	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Hospital Services **Inpatient** Bariatric Surgery/Gastric Bypass is limited to one surgery every five years. Inpatient Rehabilitation is noted under Inpatient Physical Medicine and Rehabilitation.	After the Deductible has been satisfied: $350 Copayment 15% Co-insurance	After the Deductible has been satisfied: $350 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Outpatient/Ambulatory Surgery	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Inpatient and Outpatient Professional Services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis). For more information, refer to Outpatient Therapy Services.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Maternity Care		
Office Visits Services	Covered under Doctor Office Visits.	Covered under Doctor Office Visits.
Delivery and inpatient baby care	Covered under Hospital Services.	Covered under Hospital Services.
Mental Health & Substance Abuse		
Inpatient admission	After the Deductible has been satisfied: $350 Copayment 15% Co-insurance	After the Deductible has been satisfied: $350 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Outpatient facility	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Outpatient office visit	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Therapy Services	$0 Copayment	$0 Copayment
Chemotherapy, radiation, and hemodialysis	15% Co-insurance	50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Physical, Occupational and Speech Therapy Physical Therapy, Speech Therapy and Occupational Therapy services, whether for rehabilitation or habilitative purposes, are limited to an aggregate maximum of 120 visits/days, Inpatient and Outpatient, combined, per Benefit Period.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Chiropractic Care and Spinal Manipulation Therapy Limited to a combined maximum of 50 visits per Benefit Period.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Cardiac Rehabilitation Benefits are paid up to 36 visits per Benefit Period for cardiac rehabilitation. The program must start within 3 months of the major cardiac event and be completed within 6 months of the major cardiac event.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Preventive Care Services In-Network services required by law are not subject to Deductible. Services include those that meet the requirements of federal and State law including certain screenings, immunizations, all prescribed FDA approved contraceptives and office visits. You can find the current set of preventive benefits at http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Preventive-Care/	$0 Copayment 0% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Skilled Nursing Care Copayment is waived if admitted directly to a Skilled Nursing Care Facility from an inpatient Acute Care Facility. Limited to 100 days per Member, per Benefit Period.	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Surgery		
Inpatient admission	After the Deductible has been satisfied: $350 Copayment 15% Co-insurance	After the Deductible has been satisfied: $350 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Outpatient treatment	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Ambulatory Surgical Center	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Temporomandibular & Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Transplant Human Organ & Tissue The following services are covered subject to approval by Anthem: Procurement up to a maximum Anthem payment of $15,000 per transplant. Travel expense up to a maximum Anthem payment of $10,000 per transplant. Daily lodging and meals up to a maximum Anthem payment of $200 per day. **Unrelated Donor Search -** $30,000 maximum benefit limit per transplant. See Certificate for details on covered transplants.	After the Deductible has been satisfied: $350 Copayment 15% Co-insurance	After the Deductible has been satisfied: $350 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Urgent Care Center Care is covered In-Network and Out-of-Network. For laboratory and pathology services see Diagnostic Services; Outpatient. For x-ray services see Outpatient Diagnostic Tests.	After the Deductible has been satisfied: $25 Copayment 15% Co-insurance	After the Deductible has been satisfied: $25 Copayment 15% Co-insurance

Prescription Drugs

Retail Pharmacy Prescription Drugs (Up to a 30-day supply per Prescription and/or refill.)	**In-Network** **Member Pays**	**Out-of-Network** **Member Pays**
Oral chemotherapy drugs are subject to a maximum Deductible, Copayment or Co-insurance, not to exceed $100 per Prescription and/or refill; day supply limits still apply.		
Tier 1	$15 Copayment 0% Co-insurance Deductible does not apply.	After the Deductible has been satisfied: $0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Tier 2	$30 Copayment 0% Co-insurance Deductible does not apply.	After the Deductible has been satisfied: $0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Tier 3	After the Deductible has been satisfied: $0 Copayment 15% Co-insurance	After the Deductible has been satisfied: $0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount
Tier 4 Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	After the Deductible has been satisfied: $0 Copayment 15% Co-insurance	After the Deductible has been satisfied: $0 Copayment 50% Co-insurance plus all charges in excess of the Maximum Allowed Amount

Mail Order Prescription Drugs (up to a 90-day supply per Prescription and/or refill. Tier 4 In-Network up to a 30-day supply per Prescription and/or refill.)	**In-Network** **Member Pays**	**Out-of-Network** **Member Pays**
Tier 1	$30 Copayment 0% Co-insurance Deductible does not apply.	Not Covered Not Covered

Mail Order Prescription Drugs (up to a 90-day supply per Prescription and/or refill. Tier 4 In-Network up to a 30-day supply per Prescription and/or refill.)	**In-Network** **Member Pays**	**Out-of-Network** **Member Pays**
Tier 2	$75 Copayment 0% Co-insurance Deductible does not apply.	Not Covered Not Covered
Tier 3	After the Deductible has been satisfied: $0 Copayment 15% Co-insurance	Not Covered Not Covered
Tier 4 (30-day supply) Coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	After the Deductible has been satisfied: $0 Copayment 15% Co-insurance	Not Covered Not Covered

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members to the end of the month in which they turn age 19. Covered Dental Services are subject to the same Annual Deductible and Out-of-Pocket Annual Maximum as medical and amounts can be found on the first page of this Summary of Benefits. The only exception is Diagnostic and Preventive Services which are not subject to the Annual Deductible. Please see the Dental Services – Dental Care for Pediatric Members in the Member Benefits (What is Covered) section of this Policy for a detailed description of services.

Pediatric Dental Care	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic and Preventive Services	10% Co-insurance	30% Co-insurance
Basic Restorative Services	40% Co-insurance	50% Co-insurance
Oral Surgery Services	50% Co-insurance	50% Co-insurance
Endodontic Services	50% Co-insurance	50% Co-insurance
Periodontal Services	50% Co-insurance	50% Co-insurance
Major Restorative Services	50% Co-insurance	50% Co-insurance
Prosthodontic Services	50% Co-insurance	50% Co-insurance
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	50% Co-insurance	50% Co-insurance

Pediatric Vision Services

The following benefits are available to 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. Visit our website or call the number on Your ID card for help in finding a Blue View Vision Provider. Out-of-Network Providers may bill You for any charges that exceed the plan's Maximum Allowed Amount. Covered Vision Services are **not** subject to the Deductible.

Pediatric Vision Care	In-Network Member Pays	Out-of-Network Reimbursement
Routine Eye Exam Once every Benefit Period	$0 Copayment	$30
Standard Lenses* Once every Benefit Period		
Single Vision	$0 Copayment	$25
Bifocal	$0 Copayment	$40
Trifocal	$0 Copayment	$55
Progressive	$0 Copayment	$40
Lenticular	$0 Copayment	$70
Lenses include a choice of glass or plastic lenses, factory scratch coating, standard polycarbonate and standard photochromic lenses, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses at no additional cost when received In-Network.		
Frames*(formulary) This plan offers a selection of covered frames. Once every Benefit Period	$0 Copayment	$45
Contact Lenses*(formulary) This plan offers a selection of covered contact lenses. Once every Benefit Period		
Elective (conventional and disposable)	$0 Copayment	$60
Non-Elective	$0 Copayment	$210
Low Vision		
Comprehensive Low Vision Exam Once every Benefit Period	$0 Copayment	Not Covered
Optical/Non-optical	$0 Copayment	Not Covered

aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per Benefit Period.		

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

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

Anthem Gold Pathway X PPO 750/15%

Anthem

Anthem BlueCross BlueShield

Welcome

Welcome to Anthem, where Our mission is to improve the health of the people We serve. You have enrolled in a quality health benefit plan that pays for many health care expenses, including expenses for Physician and outpatient care, Emergency care and Hospital inpatient care.

Please review this document, as well as any enclosures, to become familiar with benefits, including their limitations and exclusions. Then keep this Certificate in a convenient place for quick reference. By learning how coverage works, You can help make the best use of Your health care coverage.

For questions about Your coverage, please call Anthem's Customer Service department during regular business hours at 1-855-711-8949 or visit Anthem's website at www.anthem.com. This information is also located on the Subscriber's Identification Card.

Ten days to review

If this Certificate is provided to You as a new Subscriber, then You shall have the right to read the Certificate and any amendments. If the Subscriber is not satisfied for any reason, the Subscriber may notify Us in writing within 10 days of the Effective Date to terminate the insurance coverage. We will refund to the Subscriber all Premiums paid for that 10 day period unless benefits have been paid, in which case We will use the Premium payments to offset benefit payments. We also reserve the right to recover any benefit payments We have made for claims during that 10 day period.

Thank You for selecting Anthem for Your health care coverage. We wish You good health.

Mike Murphy
President and General Manager
Anthem

Division of Insurance Inquiries

For inquiries about health care coverage in Nevada, please call the Division of Insurance within the Department of Business and Industry between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday and ask for the Division of Insurance. The toll free number is (888) 872-3234 and the local numbers are (775) 687-0700 in Carson City and (702) 486-4009 in Las Vegas.

Although the numbers above are designed to assist Members with inquiries and Complaints about health care coverage in Nevada, the Division of Insurance is not equipped to resolve customer service related inquiries. Please continue to refer these types of inquiries to Anthem's customer service department at 1-855-711-8949. The customer service phone number is listed on the Subscriber's Identification Card.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

How to Get Language Assistance

Anthem is committed to communicating with Our Members about their health plan, no matter what their language is. Anthem employs a language line interpretation service for use by all Customer Service call centers. Simply call the Customer Service phone number on the back of Your Identification Card and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

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

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

Acceptance of coverage

Acceptance of coverage under this Certificate constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this Certificate.

Health benefit coverage is defined in the following documents:

This Certificate, the Summary of Benefits, and any amendments or endorsements thereto

- The Nevada Individual Enrollment Application for the Subscriber and the Subscriber's Dependents
- Identification Card

Anthem, or anyone acting on Our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this Certificate. In the event of any question as to the interpretation of any provision of this Certificate, Anthem's determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or, in the case of Surgery, cosmetic. However, a Member may utilize all applicable Complaint, Grievance and Appeal procedures available under this Certificate.

This Certificate is not a Medicare Supplement policy. If You as a Member are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem Blue Cross and Blue Shield. Contact Anthem's Customer Service department for assistance on how to obtain this information.

Contract with Anthem: The Subscriber hereby expressly acknowledges that the Subscriber understands that the Certificate constitutes a contract solely between the Subscriber and Anthem, an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Anthem to use the Blue Cross and Blue Shield Service Mark, and in doing so, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. The Subscriber further acknowledges and agrees that the Subscriber has not entered into the Certificate based on representations by any person other than an Anthem representative, and that no person, entity or organization other than Anthem will be held accountable or liable to the Subscriber for any of Anthem's obligations created under the Certificate. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the Certificate.

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Member Rights And Responsibilities

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Policy.
- Work with Your doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private by following our privacy policies, and State and Federal laws.
- Get the information You need to help make sure You get the most from Your health plan, and share Your feedback. This includes information on:
    - Our company and services.
    - Our network of health care Providers.
    - Your rights and responsibilities.
    - The rules of Your health plan.
    - The way Your health plan works.
- Make a Complaint or file an Appeal about:
    - Your health plan and any care You receive.
    - Any Covered Service or benefit decision that Your health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may get in the future. This includes asking Your doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

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 Policy. This may include information about other health insurance benefits You have along with Your coverage with us.

- Inform Customer Service if You have any changes to Your name, address or family Members covered under Your Policy.

If You would like more information, have comments or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Customer Service 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 Policy are overseen by the Certificate of Coverage or Summary of Benefits and not by this Member Rights and Responsibilities statement.

How Your Plan Works

Introduction

Your plan is a PPO plan. The plan has two sets of benefits: In-Network and Out-of-Network. If You choose an In-Network Provider, You will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Co-insurance. If You use an Out-of-Network Provider, You will have to pay more out-of-pocket costs.

If You need to see a Specialist who is within Your Service Area, You can visit any In-Network Specialist including a behavioral health Provider, without a referral. If You need to see a Specialist who is not within Your Service Area, please contact Your PCP to get a referral. But remember, even when a service does not require a referral, or even when You have a referral from Your PCP, some services will still require an authorization. For more information about authorizations, please see the "Requesting Approval for Benefits" later in this section. For more information about the plan's Service Area, please see the "Summary of Benefits."

In-Network Services

When You use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with Us to care for You. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, and pediatricians. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

Referrals are not needed to visit an In-Network Specialist, including behavioral health Providers, within your Service Area. If you need to see a Specialist who is outside of your Service Area, please contact your PCP to get a referral. But remember, even when a service does not require a referral, or even when you have a referral from a PCP, some services will still require an authorization.

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.

For services from In-Network Providers:

1) You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Co-insurance, Copayments, and/or Deductibles that apply.) You may be billed by Your In-Network Provider(s) for any non-Covered Services You get or when You have not followed the terms of this Certificate.
2) Precertification will be done by the In-Network Provider.

We do not guarantee that an In-Network Provider is available for all services and supplies covered under your PPO plan. For some services and supplies We may not have arrangements with In-Network Providers.

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.

Out-of-Network Services

When You do not use an In-Network Provider, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Certificate.

For services from an Out-of-Network Provider:

1) In addition to any Deductible and/or Co-insurance/Copayments, the Out-of-Network Provider can charge You the difference between their bill and the plan's Maximum Allowed Amount;
2) You may have higher Cost Sharing amounts (i.e., Deductibles, Co-insurance, and/or Copayments);
3) You will have to pay for services that are not Medically Necessary;
4) You will have to pay for non-Covered Services;
5) You may have to file claims; and
6) You must make sure any necessary Precertification is done.

We will not deny or restrict Covered Services just because You get treatment from an Out-of-Network Provider; however, You may have to pay more.

We pay the benefits of this Certificate directly to Out-of-Network Providers, if You have authorized an assignment of benefits. An assignment of benefits means You want Us to pay the Provider instead of You. We may require a copy of the assignment of benefits for Our records. These payments fulfill Our obligation to You for those services.

We have 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.

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 Policy. You can also find out where they are located and details about their license or training.

- Go to the directory of In-Network Providers at www.anthem.com. Here You can find lists of Doctors, Providers, and Facilities that participate in Our network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in Our 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.

Identification Card

When You get care, You must show Your Identification Card. Only a Member who has paid the Premium for this coverage has the right to services or benefits under this Certificate. If anyone gets services or benefits which they are not allowed to receive under the terms of this Certificate, he/she must pay for the cost of the services.

Maximum Allowed (Allowable) Amount (MAA)

General

Reimbursement for services rendered by In-Network/participating and Out-of-Network 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 Contract 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 Certificate and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Preauthorization, Utilization Management or other requirements set forth in Your Certificate.

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 Co-insurance. In addition, when You receive Covered Services from a Non-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. 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 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 an In-Network Provider or an Out-of-Network or non-participating Provider.

An In-Network Provider or participating Provider is a Provider who is in the managed network for this specific plan or in a special Center of Excellence/or other closely managed specialty network. For Covered Services performed by an In-Network Provider or 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 In-Network Providers and 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 Co-insurance. Please call Customer Service for help in finding an In-Network Provider or participating Provider, or visit www.anthem.com.

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

For Covered Services You receive from an Out-of-Network Provider that have been Preauthorized 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 accepted by like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on 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; or
5) An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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

Unlike In-Network Providers or participating Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider or participating Provider will likely result in lower out of pocket costs to You. Please call Customer Service for help in finding an In-Network Provider or participating Provider, or visit Our 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-Network Provider. In order for Us to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your out of pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

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

What Does Not Count Toward the Out-of-Pocket Annual Maximum

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

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

Authorized Services

In some non-Emergency circumstances, such as where there is no In-Network Provider available for the Covered Service, We may Preauthorize the In-Network Cost-Share amounts (Deductible, Copayment, and/or Co-insurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also will authorize the In-Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency Services from an Out-of-Network Provider and are not able to contact Us 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 may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Preauthorized services information or to request Authorization.

Deductible Calculation

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 Co-insurance. An example of services not subject to the Deductible is In-Network Preventive Care Services required by law.

If this Policy covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services.

If this Policy covers 2 or more Members, one family Member or all family Members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family Member covered.

The family Deductible is also applicable for newborn and adopted children for the first 31 day period following birth or adoption if the child is enrolled or not enrolled following the 31 day period.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your plan works, please refer to the Summary of Benefits.

The Deductible and Copayment/Co-insurance amount incurred in a Year apply to the Out-of-Pocket Annual Maximum.

Out-of-Pocket Annual Maximum Calculation

The Deductible, Co-insurance,* and Copayment amounts incurred in a calendar Year apply to the Out-of-Pocket Annual Maximum.

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

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

In-Network and Out-of-Network Co-insurance and Out-of-Pocket Annual Maximums are separate and do not accumulate toward each other.

*The Out-of-Network Out-of Pocket Annual Maximum does not include Co-insurance for any Out-of-Network Human Organ Tissue Transplant.

Benefit Period Maximum

Some Covered Services have a day or visit limit that We will allow during each Benefit Period. This is called the Benefit Period Maximum. When the Deductible applies to a Covered Service that has a limit, the limit will be reduced by the amount applied the Deductible. It does not matter whether or not the Covered Service is paid by Anthem. These limits apply even if You have met the Out-of-Pocket Annual

Maximum. These limits apply even if some or all of the claims first applied to meet Your Deductible. See the Summary of Benefits for services that have a Benefit Period Maximum.

Requesting Approval for Benefits

Preauthorization: In-Network Providers must obtain Preauthorization in order for You to get benefits for certain services. Preauthorization criteria will be based on many sources including medical policy, clinical guidelines, and Pharmacy and Therapeutics guidelines. We 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 Certificate to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Certificate or is Experimental/ Investigative as that term is defined in this Certificate.
- **Post Service Clinical Claims Review** – A retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor 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 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 Preventive 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 Policy otherwise Your Certificate 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 Preauthorization phone number on the back of Your Identification Card.

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

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

Just because We exempt a process, Provider or claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We 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 the Customer Service at the number listed 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

- **Expedited** – A request for Precertification or Predetermination that is 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 Certificate was issued other State specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Expedited	72 hours from the receipt of request
Prospective Non-Expedited	15 calendar days from the receipt of the request
Continued Stay Review Expedited 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 Expedited 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 Expedited 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-Expedited	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 Certificate;
4) The service cannot be subject to an Exclusion under Your Certificate; and
5) You must not have exceeded any applicable limits under Your Certificate.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

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

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Certificate. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Us. 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.

Inter-Plan Arrangements

Out-of-area services

We have 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 Our 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 Us and other Blue Cross and Blue Shield Licensees.

Typically, when You access medical care outside Our 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 Out-of-Network Providers. Our payment practices in both cases are generally described below.

BlueCard® Program

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

When You obtain Covered Services outside Our Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

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

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

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

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any State laws mandate other liability calculation methods, including a surcharge, We calculate a member's liability for any Covered Service or supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

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

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

Travel outside the United States – BlueCard Worldwide

If You plan to travel outside the United States, call customer service to find out if Your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with You.

When You are traveling abroad and need medical care

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

If You need inpatient Hospital care, You or someone on Your behalf, should contact Us for Preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care.

Please refer to the "Requesting Approval for Benefits" paragraphs above 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, Co-insurance 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.

Membership

Eligibility

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

Subscriber

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

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2) Be qualified by the Exchange as eligible, 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 Nevada; and meet the following applicable residency standards.

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

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

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

   - Not be living in an institution;
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
   - Not be emancipated;
   - Not be receiving optional State supplementary payments (SSP); and
   - Reside in the Service Area of the Exchange.

6) Agree to pay for the cost of Premium that We require;
7) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8) Not be incarcerated (except pending disposition of charges);
9) Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10) Not be covered by any other group or individual health benefit plan.

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

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

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

For tax households with Members in multiple Exchange Service Areas:

1) If all of the Members of a tax household are not living within the same Exchange Service Area, any Member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2) If both Spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

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

1) The Subscriber's legal Spouse.
2) The Subscriber's Domestic Partner - Domestic Partner is a person, other than a Spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if:
    - He or she has chosen to share one another's lives in an intimate and committed relationship of mutual caring.
    - Desired by their own free will to enter into a Domestic Partnership.
    - The NV Secretary of State has issued a Certificate of Registered Domestic Partnership.
    - He or she shares a common residence on at least a part time basis.
    - He or she is mentally competent.
    - He or she is at least 18 years old; is not related to the Member in any way (including by blood or adoption) that would prohibit him or her from being married under State law.
    - He or she is not married to or separated from anyone else.
        a. Except as provided in this Certificate, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
        b. A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
        c. To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's Spouse's children, including stepchildren, newborn and legally adopted children 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 Certificate.

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

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

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

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

Newborn and Adopted Child Coverage

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

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

Adding a Child due to 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 Certificate must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

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

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Period 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 to the Exchange and the applicable Premium to Anthem.

Effective Dates for special enrollment periods:

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

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

1) Legal separation, dissolution of Domestic Partnership, 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 in the plan's Service Area,
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
- Termination of employer contributions, and
- Exhaustion of COBRA or state continuation 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 or state continuation Premiums prior to expiration of COBRA or state continuation coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, dissolution of a Domestic Partnership, 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.

Report life changes and qualifying life events to healthcare.gov:
https://www.healthcare.gov/how-do-i-report-life-changes-to-the-marketplace/

Statements and Forms

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

Delivery of Documents

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

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/her coverage with appropriate notice to the Exchange.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of Domestic Partnership, overage Dependent, move outside the Service Area, etc...). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, 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, overage Dependent, move outside the Service Area, etc...), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination Effective Date.
4) In the case of a termination for non-payment of Premium and the 3-month Grace Period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month Grace Period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding Grace Periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving Spouse or Domestic Partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

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

Guaranteed Renewable

Coverage under this Certificate is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Certificate 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 Certificate; and
3) This Certificate has not been terminated by the Exchange.

Loss of Eligibility

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

Rescission

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

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

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

Discontinuation of Health Coverage

We can refuse to renew Your Certificate if We decide to discontinue a health coverage product that We offer in the Individual market. If We discontinue a health coverage product, We will provide You with advance notice of the discontinuation as required by law. 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 Certificate 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 last day of the first month of the 3-month Grace Period. We must pay claims during the first month of the Grace Period but may pend claims in the second and third months subject to Our right to terminate the Certificate 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 Certificate 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 Certificate will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the Certificate is to be terminated. If You do not make the full Premium payment during the Grace Period, the Certificate will be terminated on the last day for which Premium payment is made.

After Termination

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

Removal of Members

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

What We Will Pay for After Termination

Except as provided below, We will not pay for any services provided after the Member's coverage ends even if Preauthorization was received. Benefits cease on the date the Member's coverage ends as described above. A Member may be liable for benefit payments made by Us on behalf of the Member for services provided after the Member's coverage has terminated, even if the termination was retroactive.

We are only liable for payment of expenses for Covered Services provided during the effective period of this Certificate. We are not liable for expenses incurred after coverage under this Certificate is terminated or following any amendment(s) made to this Certificate in accordance with applicable law that may affect a change in such payment. A Member may be liable for benefit payments made on behalf of the Member for services provided after the Member's coverage has terminated.

We do not cover services received after the Member's date of termination even if:

- We preauthorized the services.
- The services were made necessary by an accident, illness or other event that occurred while coverage was in effect.
- The Member was hospitalized at the time of termination.

Member Benefits (What Is Covered)

This section describes Covered Services and supplies. Services, supplies or treatments will be Covered Services if they are Medically Necessary or preventive, not otherwise excluded under this Certificate as determined by Us and obtained in the manner required by this Certificate. The Member can obtain care through an In-Network Physician or by self-referral to an In-Network Specialist including behavioral health Provider. Additionally, all services must be provided and be within the standard medical practice where they are received for the illness, injury or condition being treated, and must be legal in the United States. 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 from Us.

We base Our decisions about Preauthorization, Medical Necessity, Experimental/Investigational and new technology on medical policy developed by Us. We will also consider published peer reviewed medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.

All Covered Services are subject to other conditions and limitations of this Certificate. All Covered Services are subject to meeting Our medical policy criteria.

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 nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

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

Out-of-Network Providers may bill You for any charges that exceed Our Maximum Allowed Amount.

Ground Ambulance

Services are subject to medical necessity review by Us. All scheduled ground Ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by Us. We retain the right to select the air Ambulance Provider. This includes fixed wing, rotary wing or water transportation.

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

Hospital to Hospital Air Ambulance Transport

Air Ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air Ambulance transport is Medically Necessary, for example, if transportation by

ground Ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all 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.

Autism Spectrum Disorders

This section describes Covered Services and exclusions for the screening, diagnosis and treatment of autism spectrum disorder. Autism Spectrum Disorder is a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified. Coverage provided under this section is subject to the same cost-sharing provisions as other like medical services or Prescription Drugs are covered by this Certificate. Coverage is provided for the screening, diagnosis, and treatment of autism spectrum disorder to Members under 18 years of age or, if enrolled in high school, until the Member reaches 22 years of age. Covered Services are allowed up to the maximum visits as listed on the Summary of Benefits per Member's Benefit Period.

Screening for Autism Spectrum Disorders means Medically Necessary assessments, evaluations or tests to screen and diagnose whether a Member has an autism spectrum disorder.

Treatment of Autism Spectrum Disorders must be identified in a treatment plan and may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

(a) Prescribed for a Member diagnosed with an Autism Spectrum Disorder by a licensed Physician or licensed psychologist; and

(b) Provided for a Member diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other Provider that is supervised by the licensed Physician, psychologist or behavior analyst.

Solely as used in this Autism Spectrum Disorders section, the following terms and definitions will apply:

Applied behavior analysis - the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior. Benefits for applied behavior analysis treatment are limited to a maximum benefit as listed on the Summary of Benefits.

Behavior or Behavioral therapy - any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or Registered Behavior Technician.

Evidence-based research -research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.

Habilitative or rehabilitative care - counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

Licensed assistant behavior analyst - a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

Licensed behavior analyst - a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

Prescription care - medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the State in which the psychiatrist practices.

Psychological care - direct or consultative services provided by a psychologist licensed in the State in which the psychologist practices.

Registered Behavior Technician - a person who is Registered Behavior Technician or an equivalent by the Behavior Analyst Certification Board, Inc., and provides behavioral therapy under the supervision of a:

1) licensed psychologist;
2) licensed behavior analyst; or
3) licensed assistant behavior analyst.

Therapeutic care - services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

Treatment plan - a plan to treat an Autism Spectrum Disorder that is prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

We may request a copy of and review the autism spectrum treatment plan. Services for Autism Spectrum Disorder may be subject to Preauthorization and Utilization Management - see the REQUESTING APPROVAL FOR BENEFITS heading in the HOW YOUR PLAN WORKS section for more information.

Autism Spectrum Disorders Exclusions - Services for Autism Spectrum Disorders are subject to the same general exclusions or limitations as other medical services or Prescription Drugs covered by this Certificate. See the GENERAL EXCLUSIONS section of this Certificate.

Bariatric Surgery

Bariatric Surgery and complications from bariatric Surgery that satisfy Our medical policy are covered.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved Clinical Trial if the services are Covered Services under this Plan. An “approved Clinical Trial” means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. It also includes a Phase II, Phase III or Phase IV study or Clinical Trial for the treatment of chronic fatigue syndrome. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated, including, but not limited to, chronic fatigue syndrome.

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.
4) Before participating in an Approved Clinical Trial, the Member has signed a statement of consent indicating that they have been informed of, without limitation: (a) the procedure to be undertaken; (b) alternative methods of treatment; and (c) the risks associated with participation in the Approved Clinical Trial or, including, without limitation, the general nature and extent of such risks.

We may require You to use an In-Network Provider to maximize Your benefits.

Routine patient care costs include item, services and drugs provided to You in connection with an approved Clinical Trial and that would otherwise be covered by the 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.

We are not required to provide benefits for the following services. We reserve Our right to exclude any of the following services

1) The Investigational item, device, or service, itself; or
2) 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
3) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4) Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Related Services

This section describes Covered Services and exclusions for accident related Dental Services, Anesthesia for children, inpatient services for dental related services, and temporomandibular joint care. **This Dental Related Services section provides coverage for health conditions and should not be considered as the Member's dental coverage.** All Dental Services and supplies are subject to Preauthorization guidelines. See the section HOW YOUR PLAN WORKS, under the heading REQUESTING APPROVAL FOR BENEFITS for information on Preauthorization guidelines.

Dental Anesthesia

Benefits are provided for general Anesthesia when provided in a Hospital, outpatient surgical facility or other facility, and for associated Home Health Services or facility charges for dental care is provided to a covered Dependent child who:

- has a physical, mental or medically compromising condition;
- has dental needs for which local Anesthesia is not effective because of acute infection, an anatomic anomaly or allergy;
- is extremely uncooperative, unmanageable, or anxious; or
- has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation.

Dental service related to an accident

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

- Dental Services, supplies and appliances are needed because of an accident in which the Member sustained other significant bodily injuries outside the mouth or oral cavity.
- Treatment must be for injuries to Your sound natural teeth.
- Treatment must be necessary to restore Your teeth to the condition they were in immediately before the accident.
- The first Dental Services must be performed within 90 days after Your accident.
- Related services must be performed within one year after Your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances We determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

Inpatient Admission for Dental Care

Benefits are provided for inpatient facility services including room and board, but do not include charges for the Dental Services, **only** if the Member has a non-dental related physical condition, such as a bleeding disorder or heart condition that make the hospitalization Medically Necessary.

Other Dental Conditions

Benefits are provided in connection with conditions of the mouth (excluding teeth and gums) arising from disease, trauma, injury, or Congenital Defect, if determined to be Medically Necessary.

Diabetic Management

Benefits are provided to Members who have insulin dependent Diabetes, non-insulin dependent Diabetes and elevated blood glucose levels induced by pregnancy or other medical conditions when Medically Necessary.

Benefits are provided for Diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the Member's disease course when provided by a certified, registered, or licensed health care professional with expertise in Diabetes. Insulin pumps and related supplies are covered subject to meeting Our medical policy criteria. Replacement of pumps that are out of warranty and are malfunctioning and cannot be refurbished would be a covered service. In situations where new models or upgrades to the latest insulin pump are requested, coverage would not be available.

When Diabetic supplies are provided by a Pharmacy they are covered under the benefits for Prescription Drugs. Please refer to Your Summary of Benefits for cost sharing information. Screenings for gestational diabetes are covered under PREVENTIVE CARE SERVICES.

Diabetic Management Exclusions

Diabetic supplies and equipment are not covered when received from an Out-of-Network Provider.

Diagnostic Services

Your Policy 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.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Certificate includes benefits for Durable Medical Equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.

- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Benefits include hearing aids. Benefits for hearing aids are limited to a maximum benefit as listed on the Summary of Benefits.

Orthotics

Benefits are available for certain types of Orthotics (braces, boots, and splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Certificate also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories;
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
3) Breast Prosthesis (whether internal or external) after a mastectomy, as required by the applicable law.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.

Medical and Surgical Supplies

Your Certificate includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Medical Supplies and Equipment Exclusions - The following services, supplies or care are not covered:

- Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames or cryocuff unit). Equipment or appliance the Member requests which includes more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used, such as electric wheelchairs or electric scooters).
- Any items available without a prescription such as over the counter items and items usually stocked in the home for general use, including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly.

- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, and biofeedback equipment.
- Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition. These include, but are not limited to, bath accessories, home modifications to accommodate wheelchairs, wheel chair convenience items, wheel chair lifts, vehicle modifications.
- Dental Prosthesis, hair/cranial Prosthesis, penile Prosthesis or other Prosthesis for cosmetic purpose.
- Orthotics (except for Members with diabetes), whether functional or otherwise, regardless of the relief they provide.
- Home exercise and therapy equipment.
- Consumer beds or water beds.
- Repairs or replacements needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for Members with diabetes).

Emergency Care and Urgent Care

Emergency Services

Benefits are available in a Hospital Emergency room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means a medical condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient’s health in serious danger or, for a pregnant women, placing the women’s health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Care

“Emergency care” means a medical exam done in the Hospital Emergency room, and includes services routinely available in the Emergency department to evaluate an Emergency condition. It includes any further medical exams and treatment required to Stabilize the patient.

If You are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary services will be covered whether You get care from an In-Network or Out-of-Network Provider. Emergency care You get from an Out-of-Network Provider will be covered as an In-Network service.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your Provider call Us as soon as possible. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. See Summary of Benefits for more details. If You or Your Provider does not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Emergency care is limited to those services needed to screen and Stabilize Your condition. Stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Member 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.

Urgent Care

Benefits are provided for accident or medical care received from an Urgent Care center or other facility such as a Physician's office. Urgent Care is not considered a life or limb-threatening Emergency and does not require the use of an Emergency room.

Emergency Care and Urgent Care Exclusions

The following services, supplies or care are not covered:

- Follow-up care received in an Emergency department or Urgent Care center, including but not limited to, removal of stitches and dressing changes.
- Maternity care and/or deliveries outside the Service Area within five weeks of the anticipated delivery date, except in an Emergency.
- Non-Emergency continued care after the Member's condition has Stabilized.

Family Planning

This section describes Covered Services and exclusions for birth control and infertility.

Birth Control

Birth control benefits include family planning counseling and birth control devices, provided in a Physician's office or an In-Network facility.

Benefits are also provided for surgical sterilization for men (e.g., vasectomy) and related services.

Certain contraceptives and surgical sterilization services for women are covered as Preventive Care. Please see the PREVENTIVE CARE SERVICES heading in this section for further details.

Birth Control Exclusions

The following services, supplies or care are not covered:

- Over the counter products for birth control purpose (e.g., sponges, spermicides and condoms)
- Reversals of voluntarily induced sterility.

Infertility

Infertility benefits include the following Covered Services:

Limited diagnostic and therapeutic infertility services determined to be Medically Necessary and Preauthorized by Us. Covered Services do not include those services specifically excluded herein, but do include limited:

- Laboratory studies.
- Diagnostic procedures; and
- Artificial insemination services, up to 6 cycles per Member per lifetime.

Infertility Exclusions

The following services, supplies or care are not covered:

- Services when the obstruction is related to the reversal of a surgical sterilization.
- Hormonal manipulation and excess hormones to increase production of mature ova for fertilization.
- Any service, supply or drug used in conjunction with or for the purpose of an artificially induced pregnancy including Artificial Reproductive Technology (ART).
- Test tube fertilization, drugs for induced ovulation or other artificial methods of conception, except as specifically covered above.

- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT) and any related services.
- Cost of donor sperm or donor eggs.
- Diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy.
- Storage costs for sperm or frozen embryos.
- Home pregnancy or ovulation tests.
- Sonohysterography.
- Monitoring of ovarian response to stimulants.
- CT or MRI of sella turcica unless elevated prolactin level.
- Evaluation for sterilization reversal.
- Laparoscopy.
- Ovarian wedge resection.
- Removal of fibroids, uterine septae and polyps.
- Open or laparoscopic resection, fulguration, or removal of endometrial implants.
- Surgical lysis of adhesions.
- Surgical tube reconstruction.

Food and Nutrition

This section describes Covered Services and exclusions for nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, Durable Medical Equipment and pharmaceutical services. An In-Network licensed therapist or Home Health Agency must provide the nutrition services. All services must be preauthorized, see the REQUESTING APPROVAL FOR BENEFITS heading in the HOW YOUR PLAN WORKS section for information on Preauthorization guidelines.

Enteral therapy and Total Parenteral Nutrition

Enteral therapy is delivery of nutrients by a tube into the gastrointestinal tract.

Total Parenteral Nutrition (TPN) is the delivery of nutrients through an intravenous line directly into the bloodstream.

Nursing visits to assist with enteral nutrition are covered under the home health benefits when Medically Necessary and is not considered Custodial Care. These services are frequently provided through a Home Health Agency. More information can be found under the heading HOME HEALTH CARE/HOME INFUSION (IV) THERAPY and HOSPICE CARE.

Benefits are provided for use at home for enteral formulas that are prescribed or ordered by a Physician for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from Congenital Defect or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat metabolism. Special food products that are prescribed or ordered by a Physician as Medically Necessary are allowed. Coverage is provided whether or not the condition existed when coverage began under this Certificate.

TPN received in the home is a covered benefit when it is determined to be Medically Necessary.

Food and Nutrition Exclusions

The following services, supplies or care are not covered:

- Enteral feedings.
- Tube feeding formula except as provided above.
- Food, meals, formulas, and supplements other than those listed above, even if the food, meal, formula or supplement is the sole source of nutrition, other than as provided above.
- Breast feeding education, see PREVENTIVE CARE SERVICES section for coverage of breast feeding support.

- Baby formulas.
- Feeding clinics.

Home Health Care/Home Infusion (IV) Therapy

Home Health Care

This section describes Covered Services and exclusions for Home Health Care and home infusion (IV) therapy. Benefits are provided for services performed by a Home Health Agency engaged in arranging and providing nursing services, home health aide services and other therapeutic services. Home Health Services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home Health Services must be rendered pursuant to a Physician's written order, under a plan of care established by the Physician in collaboration with a Home Health Agency. We must preauthorize all services and reserves the right to review treatment plans at periodic intervals.

Covered Services include, but are not limited to the information listed below, and are allowed up to the maximum visits as listed on the Summary of Benefits per Member's Benefit Period:

- Professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N).
- Certified Nurse Aide services under the supervision of a Registered Nurse or a qualified therapist with professional nursing services.
- Physical Therapy provided by a licensed physical therapist.
- Occupational Therapy provided by a licensed occupational therapist or certified Occupational Therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical Supplies (including respiratory supplies), Durable Medical Equipment (rental or purchase), oxygen, appliances, prostheses and Orthopedic Appliances.
- Intravenous medications and other Prescription Drugs ordinarily not available through a Retail Pharmacy.
- Nutritional counseling by a nutritionist or dietitian.
- Private duty nursing in the home.

Home infusion (IV) Therapy

Benefits for home infusion (IV) therapy include a combination of nursing, Durable Medical Equipment and pharmaceutical services in the home. Home IV therapy includes but is not limited to antibiotic therapy, hydration therapy and Chemotherapy. Intra-muscular, subcutaneous and continuous subcutaneous injections are also Covered Services. See the FOOD AND NUTRITION heading in this section for information on Total Parenteral Nutrition (TPN) and enteral therapy.

Home Health Care Exclusions

The following services, supplies or care are not covered:

- Services of a mental health social worker. Refer to the MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES heading in this section for those services We cover.
- Services or supplies for personal comfort or convenience including homemaker services.
- Food services, meals, formulas, and supplements other than listed above or resulting from dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Religious or spiritual counseling.

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 Summary of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the GENERAL EXCLUSIONS section for services that are not covered.

Covered Services include, but not limited to:

- 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. Inpatient respite care may be limited to a maximum of five consecutive days per admission.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical Therapy, Occupational Therapy, Speech Therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member's death. Bereavement services are available to surviving covered family Members.
- Bereavement support services for the covered family Members during the twelve-month period following the death of the Member.

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.

See the Summary of Benefits for any applicable Deductible, Co-insurance, Copayment and Benefit Limitation information.

Inpatient Facility Services

Inpatient Hospital Care

Covered Services include Acute Care in a Hospital setting. Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Certificate will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.

- Meals, special diets.
- General nursing services.

Benefits for Ancillary Services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, Anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problems calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when asked for by Your Physician. Benefits are not available for staff Consultations required by the Hospital, Consultations asked for by the patient, routine Consultations, phone Consultations, or EKG transmittals by phone.
- Surgery and general Anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.
- Benefits include Surgery to reconstruct a breast that has been changed by a mastectomy.

Inpatient Rehabilitation Therapy

Inpatient medical rehabilitation therapy benefits for Medically Necessary care for the primary purpose of restoring and/or improving lost functions following an injury or illness, limited to a maximum number of days per the Member's Benefit Period as listed on the Summary of Benefits.

Benefits include services in a Hospital, free-standing Facility or Skilled Nursing Facility. Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time.

Benefits also include habilitative 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.

Skilled Nursing Facility

When You require inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the facility is licensed or certified under State law as a Skilled Nursing Care Facility or is otherwise licensed to provide the services, up to a maximum number of days per the Member's Benefit Period as listed on the Summary of Benefits. Custodial Care is not a Covered Service.

Maternity and Newborn Care

Benefits are provided for maternity and newborn childcare, including diagnosis; care during pregnancy and for delivery services.

Benefits are provided for:

- Inpatient, outpatient and Physician office services (including prenatal care) for vaginal delivery, cesarean section, and complications of pregnancy
- Anesthesia services.
- Routine nursery care for a covered newborn including Physician services.
- For covered newborns all Medically Necessary care and treatment of injury and sickness including medically diagnosed Congenital Defects and Birth Abnormalities.
- Circumcision of a covered newborn male.
- Laboratory Services related to prenatal care or postnatal care.
- Abortions in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).
- Genetic testing when allowed by Our medical policy.

Important Note About Maternity Admissions: Under federal law, We may not limit benefits for any Hospital stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours following a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get Authorization from Us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

For information about enrolling a newborn child, see the DEPENDENTS heading in the MEMBERSHIP section.

Maternity and Newborn Care Exclusions

The following services, supplies or care are not covered:

- Non-emergent maternity care and/or deliveries outside the Service Area.
- Services including but not limited to preconception counseling, paternity testing, genetic counseling, or testing for inherited disorders, screening for disorders, discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Services including but not limited to paternity testing, genetic testing for inherited disorders, screening for disorders, discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Storage costs for umbilical blood.

Mental Health and Substance Abuse Services

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

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

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

Office Visits and Doctor Services

This section describes Covered Services and exclusions for Office Visits and Doctor services. For You to receive these benefits, the medical care and services must be received in a Physician's office from a Physician or other Professional Provider.

Benefits are provided for medical care, Consultation/Second Opinions to examine, diagnose, and treat an illness or injury when received in a Physician's or other Professional Provider's office. A Physician may also provide medication management for medical conditions or mental health disorders. Consultation/Second Opinions may be provided by another Physician at the request of the Physician or the Member. In certain cases, We may request a Second Opinion.

Benefits are provided for office-based Surgery and surgical services, which includes Anesthesia and supplies. Such surgical fees include local Anesthesia and normal post-operative care. Office-based surgical services are subject to Preauthorization guidelines. See the REQUESTING APPROVAL FOR BENEFITS heading in the HOW YOUR PLAN WORKS section for information on Preauthorization guidelines.

Benefits are provided in a Physician's office for diagnostic services when required to diagnose or monitor a symptom, disease or condition. Benefits are also provided for genetic disease testing services. Subject to the Member's coverage, certain services are subject to additional Deductibles, Copayments and/or Co-insurance such as MRI, MRA, CT, and PET scans; see the Summary of Benefits for additional information.

Office Visits for medical care (including Second Surgical Opinions) to examine, diagnose, and treat an illness or injury.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Health Care Services" benefit described earlier in this Certificate.

Retail Health Clinic Care for limited basic health care services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician's Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

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.

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.

For a listing of In-Network Providers or Urgent Care centers please visit Our website at www.anthem.com.

Office Visits and Doctor Services Exclusions

The following services, supplies or care are not covered:

- Expenses for obtaining medical reports or transfer of files.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata.
- Routine foot care such as care for corns, toenails or calluses except for Members with diabetes.
- Telephone or Internet Consultations, except where online visit services are specifically covered above as a Physician Office service.
- Treatment for sexual dysfunction.
- Genetic counseling.
- Separate reimbursement for Anesthesia and post-operative care when services are provided by the same Physician in the Physician's office.
- Peripheral Bone Density Scans.
- Online visit do not include reporting normal lab or other test results, office appointment requests, billing, insurance coverage or payment questions, requests for referrals to Doctors outside the online care panel, benefit precertification, and Physician to Physician Consultation.

Outpatient Facility Services

Your Certificate includes Covered Services in an:

- Outpatient Hospital.
- Ambulatory Surgical Center.
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by Us.

Benefits include Facility and related charges, when Medically Necessary, such as:

- Surgical rooms and equipment.
- Prescription Drugs, including Specialty Drugs given by the Hospital or other Facility.
- Anesthesia and Anesthesia supplies and services given by the Hospital or other Facility.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Outpatient Therapies

This section describes Covered Services and exclusions for Physical Therapy, Speech Therapy, Occupational Therapy, cardiac rehabilitation and chiropractic care.

Physical, Speech and Occupational Therapies

Physical Therapy may involve a wide variety of evaluation and treatment techniques. Such therapy is given to relieve pain, restore function, and prevent disability following illness, injury, loss of a body part, or Congenital Defect or Birth Abnormality. All care must be received from a licensed physical therapist.

Speech Therapy is for the correction of speech impairment resulting from illness, injury or Surgery as determined by Our medical policy. All care must be received from a licensed speech therapist.

Occupational Therapy is the use of constructive activities designed to promote the restoration of the Member's ability to satisfactorily accomplish the ordinary tasks of daily living. All care must be received from a licensed occupational therapist.

Benefits are provided up to the maximum number of visits as listed on the Summary of Benefits.

Other Outpatient Therapy Services

- Cardiac rehabilitation is a program to restore an individual's functional status after a major cardiac event. Benefits are allowed at an In-Network facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient cardiac rehabilitation program. See the Summary of Benefits for visit limits.
- Chiropractic benefits are allowed for services administered by a chiropractor who acts within the scope of their license for the chiropractic treatment of an illness of Accidental Injury. Chiropractic benefits are limited to office visits for manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Please refer to Your Summary of Benefits for visit limits.
- Benefits are provided for manipulation therapy for pain management. See the Summary of Benefits for visit limits.

Outpatient Therapies Exclusions

The following services, supplies or care are not covered:

- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders. Therapies (including but not limited to Speech Therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, stuttering, voice or rhythm disorders.
- Benefits are not covered for non-specific diagnoses relating to learning-related disorders.
- Therapeutic exercise equipment prescribed for home use such as treadmills and/or weights.
- Convenience items as determined by Us.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to worker's compensation injuries.
- Therapies and self-help programs not specifically identified as a Covered Service above.
- Recreational, sex, primal scream, sleep and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self help, stress management and weight loss programs.
- Smoking cessation programs. This does not include services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) which is explained in the PREVENTIVE CARE SERVICES section of this Certificate.
- Transactional analysis, encounter groups and transcendental meditation (TM).
- Sensitivity training, anger management or assertiveness training.
- Rolfing, pilates, Myotherapy or prolotherapy.
- Holistic Medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes are not covered, except as otherwise specifically provided herein.

- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational or vocational therapies (e.g., hobbies, arts and crafts).
- Acupuncture care except as provided herein.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Co-insurance 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 Summary of Benefits to determine Your Copayment, Co-insurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Co-insurance will not be reduced by any discounts, rebates or other funds received by Our designated Pharmacy Benefits Manager from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Us from Our designated Pharmacy Benefits Manager.

Prescription Drug List

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

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

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

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

Your Policy 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 Our other 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 Us. We may add or delete Prescription Drugs from this Formulary from time to time as permitted by law. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Exception Request for a Drug not on the Prescription Drug List

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

Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving Your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills.

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

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription 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).

Where You Can Obtain Prescription Drugs

In-Network Pharmacy

Your Certificate 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 Summary of Benefits for any Copayment, Co-insurance, 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 In-Network Pharmacies may be limited. If this happens, We may require You to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single In-Network Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single In-Network Pharmacy for You.

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

Maintenance Medication – Home Delivery Complete

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

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to antibiotics, Drugs not on the Formulary, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at the 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 Our 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 any of Our offices.

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 customer 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 Preauthorization. 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 Co-insurance as found in the Summary 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 the telephone number on the back of Your Identification Card or online at www.anthem.com. You or Your Physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Urgent or Emergency need of a Specialty Drug subject to the Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Co-insurance, 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 an In-Network Pharmacy near You. A customer service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Co-insurance.

Important Details About Prescription Drug Coverage

Your Certificate 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 Preauthorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other Utilization Reviews. Your In-Network 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 Preauthorization. Also, an In-Network Pharmacist can help arrange Preauthorization 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 overutilization of Drugs.

Preauthorization

Preauthorization 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 Preauthorization should be given. We will give the results of Our decision to both You and Your Provider.

If Preauthorization is denied You have the right to file a Grievance as outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section of this Certificate.

For a list of Drugs that need Preauthorization, 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 Certificate. 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 Certificate.

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 Preauthorization will apply.

Administered by a Medical Provider

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

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

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the Summary 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 our Specialty Pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free Member Services number on your Member Identification 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 Co-insurance 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 Us. The telephone number for Member Services is printed on the Member's Identification Card.

Our address is:

Anthem
Member Services
P.O. Box 5747
Denver, CO 80217-5747
Monday through Friday – 7:30 a.m. to 6:30 p.m.

Preventive Care Services

This section describes Covered Services and exclusions for Preventive Care.

Preventive Care services include screenings and other services are 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.

If You 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 Physician Office benefit.

Preventive Care services in this section shall meet requirements as determined by federal and State law including but not limited to the Patient Protection and Affordable Care Act (PPACA), and are to become effective in accordance with those laws. Many Preventive Care services are covered by this Certificate with no Deductible, Copayment, and/or Co-insurance from the Member. 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 children, adolescents, and adults as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes Child Health Supervision Services.
4) Additional Preventive Care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    - Women’s contraceptives, sterilization procedures, and counseling. This includes generic and single source drugs as well as injectable contraceptives and patches. Contraceptive

devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. Multi-source drugs will be covered as Preventive Care benefits when Medically Necessary, otherwise they will be covered under the Prescription Drug benefit and subject to the Cost Sharing Prescription Drugs.
- Breastfeeding support, supplies, and counseling. Breast pumps must be received from an In-Network Provider. Benefits for breast pumps are limited to one per Benefit Period or as required by law.
- Gestational diabetes screening.

Additional women's Preventive Care services include well-woman visits, HPV testing, counseling for sexually transmitted infections, counseling and screening for HIV, and counseling and screening for interpersonal and domestic violence.

You may call Customer Service at the number on Your Identification Card for additional information about these services. You may also visit the federal government websites:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Covered Services also include services required by State law, including those for colorectal cancer and prostate cancer screenings in accordance with the American Cancer Society.

Preventive Care services mean care that is rendered to prevent future health problems for a Member who does not exhibit any current symptoms. Coverage for benefits in this section shall meet or exceed those required by law. Coverage may vary based on Your age, sex and/or personal history. Preventive Care services are developed from national guidelines recommended by such agencies as the U.S. Preventive Services Task Force, the American Cancer Society, and the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. Consult with Your Physician for specific health guidelines. See Your Summary of Benefits for any cost share and limitations.

Preventive Care Services include:

Routine Exams and Immunizations

- Routine or periodic exams, e.g., pelvic exams, Exams are covered according to the frequency determined by Your Provider.
- Family history, current health problems and lifestyle all affect Your risk for disease. Talk to Your Provider to determine if You are at high risk for specific diseases and then together determine Your appropriate exam schedule.
- Immunizations (including those required for school) and immunizations against cervical cancer, including expenses incurred for administering the human papillomavirus vaccine (HPV), to the extent required by applicable law. Immunizations protect You from certain diseases and help prevent epidemics. While immunization risks to Your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy.
- Annual medical diabetes eye exams, or in accordance with the frequency determined by Your Provider.
- Annual flu shot benefit when You receive a flu shot at Your Provider's office. Reimbursement for one flu shot per Benefit Period, or as determined by Us, at locations such as a flu shot clinic held at Your place of work, or at a local retail store, may also be available. The claim form You need to submit for reimbursement and the reimbursement amount is available on Our website at www.anthem.com or call Our customer service department. This annual reimbursement is subject to change. A flu shot that is otherwise paid for in full or in part by another party is not covered.

Routine/Preventive Diagnostic Services

- Routine screening mammogram.
- Routine cytologic screening (Pap test).
- Routine prostate specific antigen (PSA) blood test and digital rectal exam.
- Colorectal cancer examination.
- Routine PKU tests for newborns.

Coverage for benefits in this section shall meet or exceed those required by law.

Preventive Care Exclusions

The following services, supplies or care are not covered:

- Routine exams and immunizations related to sports, insurance, condition of employment, for licensing, school, church or camps.
- Immunizations for travel.
- Routine care received in the Emergency room.

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 Policy.

Note: This section does not apply to orthognathic surgery.

Mastectomy Notice

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

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

Members will have to pay the same Deductible, Co-insurance and/or Copayments that normally apply to surgeries in this Policy.

Temporal Mandibular Joint Syndrome (TMJ)

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related Surgery, medical care, and diagnostic services. Covered Services do not include services or supplies that are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

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

This section describes benefits for certain Covered Transplant Procedures that You get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received

before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Certificate.

Covered Transplant Procedure

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

In-Network Transplant Provider

A Provider that We have 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.

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.

Unrelated Donor Searches

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

Live Donor Health Services

Donor benefits are limited to benefits not available to the donor from any other source.

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 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.

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

Transportation and Lodging

We will provide Assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 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. We assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

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

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

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

Helpful tip: See the Summary of Benefits for any applicable Deductible, Co-insurance, Copayment, and Benefit Limitation information.

Vision Care For Pediatric Members

Pediatric vision care services are available to 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. Visit our website or call the number on Your Identification Card for help in finding a Blue View Vision Provider.

We will cover vision care that is listed in this section. See Your Summary 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 GENERAL EXCLUSIONS section. Covered Vision Services are not subject to the Deductible.

Routine Eye Exam

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

Eyeglass Lenses

You have a choice in Your eyeglass lenses. Benefits include a choice of glass or plastic lenses, factory scratch coating, standard polycarbonate and standard photochromic lenses, 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 the Summary of Benefits, You will have to pay all charges for those lens options.

Covered standard eyeglass lenses include:

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

Frames

There is a Formulary of frames available to You. See Your Provider for more information.

Elective Contact Lenses*

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

Non-Elective Contact Lenses

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

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

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

This plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a benefit period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglass lenses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

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 maximum the Member's vision.

Vision Coverage Appeals

Please submit Appeals regarding Your vision coverage to the following address:

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

Dental Services – Dental Care for Pediatric Members

All Covered Services are subject to the terms, limitations, and exclusions of Your Certificate. See Your Summary of Benefits for Your Cost Share amounts, such as Deductibles and/or any Co-insurance.

Your Dental Benefits

We do 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 policy. We evaluate the procedures submitted to Us on Your claim to determine if they are a covered service under this policy.

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 policy. 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 policy. 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 Co-insurance 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, 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 policy 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 policy 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 the address on Your dental Identification Card.

Dental Providers

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

Please call Your customer service department at the number listed on Your Identification Card for help in finding an In-Network dentist or visit our website at www.anthem.com/mydentalvision. Please refer to Your Identification Card for the name of the dental program that In-Network Providers have agreed to service when You are choosing an In-Network dentist.

Description of Covered Services

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 - The following oral exams are covered:

- Periodic oral exam – 1 every 11 months
- Limited oral exam – 3 per six months
- Oral exam for patients under 3 years old
- Detailed and extensive oral exam
- Re-evaluation (limited or problem focused)

Radiographs (X-rays)

- Bitewings – 1, 2 or 4 bitewing x-rays are covered per 6-month period.
- Bitewings – 3 x-rays.
- Full Mouth (Complete Series) or Panoramic – covered 1 time per 3 Year period.
- Periapical(s) -1st single x-ray is covered 2 times per 3 months. Seventeen (17) additional single periapical x-rays are covered once per 12 months.
- Occlusal - 2 series per 12-month period.
- Vertical bitewings (7-8 x-rays).

Dental Cleaning (Prophylaxis) – Limited to 1 every 6 month period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application or varnish) - Covered 2 times per 12-month period.

Sealants - Limited to once per tooth per lifetime. Covered for permanent molars only.

Space Maintainers – Limited to 2 per 12 months up to 4 per lifetime.

Recement Space Maintainer

Basic Restorative Services

Emergency Treatment for the temporary relief of pain or infection. Limited to 2 times per 6 months.

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

Composite (white) Resin Restorations. Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth. If You choose to get a composite restoration on a posterior (back) tooth, We will pay up to the Maximum Allowed Amount for an amalgam restoration. You will be responsible to pay for the difference between the amalgam and the composite restoration, plus any applicable Deductible and/or Co-insurance.

Benefits for amalgam or composite restorations will be limited to 1 service per tooth surface per 36-month period.

Endodontic Services

Pulp vitality testing

Pulp capping (direct or indirect)

Therapeutic pulpotomy – limited to 1 tooth per 36 months. Covered for primary teeth only.

Pulpal therapy

Endodontic therapy (root canal therapy) - limited to once per tooth per lifetime.

Other Endodontic Treatments

- Apexification - limited to once per lifetime
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling - limited to once per lifetime

Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment. Limited to 2 times per 6 month period.

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

- Periodontal scaling & root planning (per quadrant) - Limited to 4 quadrants per 12 month period.
- Full mouth debridement.

Periodontal Splinting

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

- Gingivectomy/gingivoplasty (per quadrant) – limited to 4 times per 60 months;
- Anatomical crown exposure;
- Gingival flap;
- Crown lengthening;
- Osseous Surgery (per quadrant) – limited to 4 times per 60 months;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;

- Subepithelial connective tissue graft;
- Distal/proximal wedge

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation and General Anesthesia – Covered only when given with covered complex surgical services.
- Occlusal Guards
- Consultations (other than dentist providing treatment).

Other Adjunctive General Services

- Therapeutic drug injection, by report
- Treatment of complications (post-surgical)

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of torus palatines and torus mandibularis – limited to 2 times per lifetime
- Removal of exostosis-per site – limited to 2 times per lifetime

Other Oral Surgery Procedures.

- Incision and drainage of abscess (intraoral soft tissue) – limited to 3 per lifetime
- Excision of pericoronal gingival
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

Major Restorative Services

Pre-fabricated Stainless Steel Crown (for primary tooth) - Covered once per 36-month period.

Pre-fabricated Stainless Steel Crown (for permanent tooth) – Covered 1 time per tooth per lifetime.

Permanent Crowns

- Crown – resin with base metal
- Crown – porcelain fused base metal
- Crown – full cast base metal

LIMITATION: The above crowns are covered 1 time per tooth per lifetime if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

Additional crowns that are covered:

- Crown – ¾ resin-based composite
- Crown – porcelain/ceramic substrate
- Crown – ¾ cast base metal

Recement Crowns – Limited to 1 per 12 month period. Covered 6 months after initial placement.

Crown Repair

Sedative filling – Limited to 2 per 6 month period. Covered only if given with a restoration service.

Core build-up (including any pins) - Limited to 1 per 36 month period.

Pin retention (in addition to restoration) – Limited to 2 per 36 month period.

Post and core in addition to crown – Covered once per lifetime.

Prosthodontic Services

Tissue Conditioning - Covered once per 12-month period.

Reline and Rebase - Covered once per 6-month period when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered when:

- the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- once 91 days have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- when the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments - Covered 2 times per 12-month period when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments - Covered 1 time per 6-month period when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthodontic Services (Dentures and Partials) - Covered once per 60 month period:

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

Fixed Prosthodontic Services (Bridge) - Covered once every 5 year period:

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

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

Recement Fixed Prosthetic - Covered once 91 days have passed following initial placement of the prosthetic appliance (denture, partial or bridge).

Orthodontic Treatment

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

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 before 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.

Treatment in progress (appliances placed prior to being covered under this Policy) 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).

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 (Co-insurance) 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
P.O. Box 1122
Minneapolis, MN 55440-1122

Please see “Complaints, Appeals and Grievances” section for a detailed explanation of the appeal process.

General Exclusions

In this section You will find a review of items that are not covered by Your Certificate. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by Your Certificate.

We have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by Your Certificate.

These general exclusions apply to all benefits described in this Certificate. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific Covered Services, which can be found in the MEMBER BENEFITS (WHAT IS COVERED) section and elsewhere in this Certificate.

If a service is not covered, then **all** services performed in conjunction with that service are not covered. We are the authority for determining if services and supplies are Medically Necessary and if they will be covered by Certificate.

We will not allow benefits for any of the following services, supplies, situations, or related expenses:

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

Acupuncture: Services or supplies related to acupuncture care.

Affiliated Providers: 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.

After Hours or Holidays Charges: Additional charges beyond the Maximum Allowable Amount for basic and primary services requested after normal Provider service hours or on holidays.

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

Ambulance: Ambulance usage is not covered 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.

Armed Forces/War: 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.

Artificial/Mechanical Devices/Heart Condition: 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.

Breast Reduction/Augmentation: 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 a Medically Necessary mastectomy resulting from cancer. No coverage is provided for surgical treatment of gynecomastia.

Charges After Termination Date: Charges incurred after the termination date of this coverage.

Charges Before Effective Date: Incurred prior to Your Effective Date.

Cochlear Implants: For cochlear implants. Except as specified in the MEMBER BENEFITS (WHAT IS COVERED) section of this Certificate.

Complications of Non-Covered Services: Care for problems directly related to a service that is not covered by this Certificate. Directly related means that the care took place as a direct result of the non-Covered Service.

Corrective Eye Surgery: 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.

Cosmetic Services: Treatment, services, Prescription Drugs, equipment, or supplies given for Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how You look or are given for psychiatric, psychological, or social reasons. No benefits are available for Surgery or treatments to change the texture or look of Your skin or to change the size, shape, or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive for breast symmetry after a mastectomy.

Counseling Services: Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy

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

Crime: Treatment of an injury or illness that results from a crime You Committed, or tried to commit. This exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or if You were the victim of a crime, including domestic violence.

Custodial Care, Services/Care Other Facilities: We do not pay services, supplies, for the following:

- Custodial Care, convalescent care or rest cures. This exclusion does not apply to Hospice care.
- Domiciliary care regardless of the Provider rendering the care.
- 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.

Dental Care

Coverage is not provided for:

- Dental Care for Members age 19 and older, except as listed in this Certificate.
- Dental Services which a Member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law,

Federal Medicare program, or Federal Veteran's Administration program. However, if a Member receives a bill or direct charge for Dental Services under any governmental program, then this exclusion shall not apply. Benefits under this plan will not be reduced or denied because Dental Services are rendered to a Subscriber or Dependent who is eligible for or receiving medical assistance.

- Dental Services not listed as covered in this Certificate.
- New, Experimental or Investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental Services completed prior to the date the Member became eligible for coverage.
- Services of anesthesiologists, unless required by law.
- Anesthesia Services, except 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 who is certified in their profession to provide Anesthesia services.
- Analgesia, analgesia agents, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general Anesthesia when given separate from a covered complex surgical procedure.
- Dental Services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental Services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the policy.
- Bacteriologic tests.
- 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.
- Services or supplies that are medical in nature, including dental oral Surgery services performed in a Hospital. Please refer to your medical coverage to determine if this is a covered medical benefit.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.

- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances.
- Removal of pulpal debridement, pulp cap, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Dental implant maintenance or repair to an implant or implant abutment.
- Canal prep & fitting of performed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.

Education/Training: For services or supplies primarily for educational, vocational, or training purposes, except as specified in the MEMBER BENEFITS (WHAT IS COVERED) section of this Certificate.

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

Exams - Research Screenings: For examinations relating to research screenings.

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

Eyeglasses/Contact Lenses: For prescription, fitting, or purchase of eyeglasses or contact lenses except as 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.

Family/Self: Services 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.

Feet - Surgical Treatment: For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

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

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

Forms/Medical Records: For completion of claim forms or charges for medical records or reports unless otherwise required by law.

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

Hospice Care Exclusions

The following services, supplies or care are not covered:

- 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

Human Growth Hormone: Human Growth Hormone

Hyperhidrosis: For treatment of hyperhidrosis (excessive sweating).

Impotency: Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing. This exclusion shall not apply to services or supplies which are specifically covered in this Certificate, are authorized by Us, or must be covered under applicable law or regulation.

Incarceration: 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.

Infertility Treatment: Infertility procedures not specifically stated as a Covered Service in the MEMBER BENEFITS (WHAT IS COVERED) section in this Certificate.

Maintenance Therapy: 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.

Maximum Allowable Amount: In excess of Our Maximum Allowable Amounts.

Missed/Cancelled Appointments: For missed or canceled appointments.

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

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

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

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

Non-Medically Necessary Services: Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.

Nutritional and Dietary Supplements: For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Certificate 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.

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

Personal Hygiene, Environmental Control or Convenience Items: 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: Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

Pharmacy: Your Prescription Drug benefits do not cover:

- Administration Charges: charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when Clinically Equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Us to be Medically Necessary. In order for that Prescription Drug 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.
- 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 Us, 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, 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 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 Legend Drugs when any version or strength becomes available over the counter.
- 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.
- Prescription Drugs used to treat infertility.

Physical Fitness: 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.

Physician Stand-by Charges: for stand-by charges of a Physician.

Physician/Other Practitioners' Charges:

- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other Consultation or medical management service not involving direct (face-to-face) care with the Member except as specifically stated in the MEMBER BENEFITS (WHAT IS COVERED) section.
- 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.

Private Duty Nursing: for Private Duty Nursing Services unless specifically stated in the MEMBER BENEFITS (WHAT IS COVERED) section.

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

Reconstructive Services: Reconstructive services except as specifically stated in the MEMBER BENEFITS (WHAT IS COVERED) section, or as required by law.

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

Reversal of Sterilization: For reversal of sterilization.

Riot, Nuclear Explosion: For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, nuclear explosion, or nuclear accident.

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as otherwise provided herein.

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

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

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

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

Therapy – Other: Services, supplies, and equipment for the following:

- Gastric electrical stimulation.
- B. Hippotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) 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.

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Certificate.
- Services and materials that are Experimental or Investigational.
- Services or materials which are rendered prior to Your Effective Date or after this coverage ends.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by licensed personnel.
- Services and materials resulting from Your failure to comply with professionally prescribed treatment.
- Telephone Consultations.
- Prosthetic devices and services.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's Spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.

- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Certificate.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Certificate.
- Any services that are strictly cosmetic in nature, including but not limited to charges for personalization or characterization of eyewear.
- Special lens designs or coatings, other than what is specifically stated as covered in this Certificate.
- For vision care received Out-of-Network.

Vision Orthoptic Training: For vision orthoptic training.

Waived Copayment, Co-insurance, or Deductible: For any Covered Service for which You are responsible under the terms of this Certificate to pay a Copayment, Co-insurance, or Deductible and the Copayment, Co-insurance or Deductible is waived by an Out-of-Network Provider.

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

Workers Compensation: For any condition, disease, defect, ailment, or injury arising out of and in the course of employment, except as specifically covered in this Certificate.

Administrative Information

Insurance Premiums

How Premiums are Established and Changed: Premiums are the monthly charges the Member must pay Us to establish and maintain coverage. The Premium for this Certificate may change subject to, and as permitted by, applicable law.

Prior to a Premium change, We will send out written notification 60 days in advance of such change. We are not required to notify the Member of a Premium increase when a Member enters into a new age bracket. If the Member's Premium is paid beyond the Effective Date of the change, We may require the Member to pay an additional Premium or accept a refund, whichever is necessary. If the age of the Member is misstated, all amounts payable for the correct age shall be adjusted and billed to the Member.

It is the Subscriber's responsibility to pay Premiums to Us. Under no circumstances will Premium payments made on any Member's behalf or any Member be accepted from a Physician, a Hospital or any other Provider of the Subscriber's health care services or any federal or State agency. The receipt of a Premium payment from such a Provider or agency may result in termination of the Subscriber's coverage.

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 Us for any reason.

Note: We may offer incentives to Members who enroll to automatically pay Premiums electronically instead of receiving a paper bill every month.

The Subscriber must notify Us of an address change by submitting an Enrollment Application/Change Form, visiting Our website at www.anthem.com, or calling Our customer service department. Failure to receive a Premium notice due to an unreported address change (or any other reason) does not relieve the Member from the responsibility to pay required Premiums by the Premium due date.

Premium Not Received on Time: If Premiums are not paid within the Grace Period, coverage under this Certificate will automatically terminate. Where the law allows, and subject to the Grace Period section of this Certificate, termination may be effective retroactively to the last date of the period for which Premium has been paid. We will not pay for any services provided to Members on or after the date of termination. All claims paid after termination will be retroactively adjusted.

We will mail written notice of any intention not to renew this Certificate beyond the period for which the Premium has been accepted not less than 30 days prior to the Premium due date. We will mail the notice to the Subscriber's latest address in Our Membership records. A Grace Period will be granted for the payment of each Premium falling due after the first Premium, during which Grace Period the Certificate shall continue in force.

General Provisions

Catastrophic Events: In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond Our control, We may be unable to process Member claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events.

Changes to the Certificate: No agent or employed by Us may change this Certificate by giving incomplete or incorrect information, or by contradicting the terms of this Certificate. Any such situation will not prevent Us from administering this Certificate in strict accordance with its terms. Oral or written statements do not supersede the terms of this Certificate.

Fraudulent Insurance Acts: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the

policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

Insurance fraud results in cost increases for health care coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive Copayments or Deductible. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Us. If there are any discrepancies, call Our customer service department.
- Be very cautious about giving the Member's health insurance coverage information over the phone.

If fraud is suspected, Members should contact Our customer service department.

We reserve the right to recoup any benefit payments paid on behalf of a Member if the Member has committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

Medical Policy and Technology Assessment: We review and evaluate 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 Our medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Our 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.

Member's Obligation to Supply Information and Cooperate: The Member must provide Us with any information We consider necessary to determine whether, or to what extent, services are covered under this Certificate, or to carry out the other provisions of this Certificate.

The Member agrees to cooperate at all times (including while they are hospitalized) by allowing Us access to their medical records to investigate claims and verify information provided in the Nevada Individual Enrollment Application.

No Withholding of Coverage for Necessary Care: We do not compensate, reward or incent, financially or otherwise, Our associates for inappropriate restrictions of care. We do not promote or otherwise provide an incentive to employees or Physician reviewers for withholding benefit approval for Medically Necessary services to which the Member is entitled. Utilization Review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Certificate.

We do not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of Authorization for coverage; (2) reductions or limitations on Hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care Providers or Members.

Notice of Privacy Practices: We are committed to protecting the confidential nature of Members' medical information to the fullest extent of the law. In addition to various laws governing Member privacy, We have Our own privacy policies and procedures in place designed to protect Member information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website or contact Our customer service department.

Paragraph Headings: The headings used throughout this Certificate are for reference only and are not to be used by themselves for interpreting the provisions of the Certificate.

Physical Examinations and Autopsies: We have the right and opportunity, at Our expense, to request an examination of the person covered by Us when and as often as it may reasonably be required during the review of a case or claim. On the death of a Member, We may request an autopsy where it is not forbidden by law.

Refusal to Follow Recommended Treatment: If a Member refuses treatment that has been recommended by Our In-Network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see another Provider of the same specialty for a Second Opinion. The Member can also pursue the Appeal process.

Reserve Funds: No Member is entitled to share in any reserve or other funds that may be accumulated or established by Us, unless We grant a right to share in such funds.

Right of Overpayment Recovery: Whenever payment has been made in error, We will have the right to recover such payment from You or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider, except in cases of fraud or where applicable law specifies a different period of time in which to recover. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide You with notice of overpayments made by Us or You if the Recovery method makes providing such notice administratively burdensome.

Sending Notices: All Subscriber notices are considered sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

The Subscriber at the latest address in Our membership records.

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

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the Member must pursue the Member's rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an Appeal with the Nevada Division of Industrial Relations. We may pay conditional claims during the Appeal process if the Member signs a reimbursement agreement to reimburse Us for 100 percent of benefits paid that duplicate benefits paid from another source.

Services and supplies resulting from work-related illness or injury are not a benefit under this Certificate, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to State or federal law, prior to the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness covered under:

- Occupational disease laws.
- Employer's liability insurance.
- Municipal, state, or federal law.
- Workers' Compensation Act.

We will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

- The Member fails to file a claim within the filing period allowed by the applicable law.
- The Member obtains care that is not authorized by workers' compensation insurance.
- The Member's employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work related illness or injury expenses.
- The Member fails to comply with any other provisions of the Workers' Compensation Act.

Duplicate Coverage

If a Member is covered under this Certificate and is also covered by another Anthem individual Certificate, the Member is limited to the one Certificate elected by the Member, the Member's beneficiary or the Member's estate, as the case may be, and We will return all Premiums paid for all other such policies. However, We will deduct any benefits paid under the individual Certificate from the Premiums being refunded.

Medicare-Eligible Members

The Subscriber and Dependents who are non-Medicare eligible and who reside in Nevada are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Claim forms

If an Out-of-Network Provider does not bill Us directly, the Member must file the claim. You may visit www.anthem.com for claim forms. If We do not furnish a claim form to the Member within 15 days of the Member's request, the Member may submit written proof of the claim and will be considered to have complied with the requirements of this Certificate.

When and where to send claims (Notice of claims)

A completed claim must be sent to Us within 365 days after the date of service. Any claims filed after this time limit may be refused. If You were not able to file a claim within that time We will not refuse or reduce benefits if You can show that is was not reasonably possible and You file as soon as You can.

Claims sent to any authorized agent of the insurer, with information sufficient to identify the Subscriber, is considered notice to the insurer. You should make copies of the bills for Your own records and attach the original bills to the completed claim form. The bills and the claim form must be mailed to:

Anthem
Attn. Claims Department
P.O. Box 5747
Denver, CO 80217-5747

Network Access Plan

We strive to provide Provider networks in Nevada that addresses Your health care needs. The Network Access Plan describes Our Provider network standards for network sufficiency in service, access and availability, as well as assessment procedures We follow in Our effort to maintain adequate and accessible networks. To request a copy of this document, call customer service. This document is also available on Our website or for in-person review at 9133 W. Russell Road, Las Vegas, NV.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care You receive from any person. This Certificate does not give anyone any claim, right, or cause of action against Us based on the actions of a Provider of health care, services, or supplies.

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make this Certificate more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of this Certificate, We have the authority, in Our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate. We reserve the right to discontinue a pilot or test program at any time.

Relationship of Parties (Us and In-Network Providers)

The relationship between Us and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of Ours, nor are We, or any employee of Ours, 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 In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) - may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

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

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

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Certificate and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, We may offer incentives to members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

Complaints, Appeals and Grievances

This section explains what to do if a Member disagrees with Our denial, in whole or in part, of a claim, requested service or supply, and how to file a Complaint, Appeal or Grievance with Us. Please refer to the Definitions section to review defined terms.

Complaints

If the Member has a Complaint about any aspect of Our services or claims processing, the Member should contact Our customer service department or write Us at:

Anthem
Customer Service Department
P.O. Box 17549
Denver, CO 80217-7549

If the Member has questions regarding eligibility or membership, the Member should contact Our customer service department or write Us at:

Anthem
P.O. Box 172405
Denver, CO 80217-2405

Complaints can be made about many things such as Member services, claims administration, benefit determination, eligibility, quality of care, access to Providers, network adequacy, etc. Some descriptions are very narrow. A trained representative will work to clear up any confusion and resolve the Member's concerns. If the Member is not satisfied with the resolution, the Member can file an Appeal as explained under the APPEALS heading in this section.

Appeals

The Member must request an internal Appeal within 180 calendar days from the date the Member was notified of Our adverse decision. Appeals may be for Preauthorized denials or post-service denials. We will assign an employee to assist the Member in the Appeal process. The Member may send written Appeals to the following address:

Grievance and Appeals
P.O. Box 10330
Reno, NV 89520-0030

The Appeal must state plainly the reason(s) why the Member disagrees with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Member should include any documents not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision.

Through the Appeal process, the Member can access one level of Appeal, and, where appropriate, independent external review. The Member can designate a representative (e.g., the Member's Physician or anyone else of the Member's choosing) to assist the Member with filing the Appeal. In some instances, We may ask the Member to designate the Member's representative in writing. The Member or the Member's representative can review the Member's Appeal file on request, and can present evidence as part of the Appeal process.

Report appeals through healthcare.gov:

https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/

First Level Appeal

First level Appeals will be reviewed by a review board. The members of the board will not have been involved in the original coverage decision. However, a person that was involved in the original coverage decision, or a health care professional with appropriate experience, may answer questions relating to the Appeal. Unless the Member agrees to a longer period, We will provide a decision in writing within 30 calendar days after receipt of the Appeal.

Expedited Appeal

A Member or Member's representative has the right to request an expedited Appeal when the timeframes for a standard review could:

- Seriously jeopardize the Member's life or health.
- Jeopardize the Member's ability to regain maximum function; or
- Create an imminent and substantial limitation on the Member's existing ability to live independently if the Member has a disability.

Expedited Appeals will be resolved as quickly as the Member's medical circumstances require, but not later than 72 hours after receipt of the request. To request an expedited Appeal, the Member, the Member's Provider or the Member's representative can contact customer service at the phone number on the Member's Identification Card, fax the request to (775) 448-4277 or send a written request to address above.

Independent External Review Appeal

If Our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment the Member requested, the Member may have the right to independent external review, where Our decision will be reviewed by health care professionals who have no association with Us. The Member may also request an independent external review when a claim has been denied based upon a determination that the recommended or requested health care service or treatment is Experimental or Investigational treatment. Except as noted below, in order to request an independent external review, the Member must have first completed a first level Appeal. But if We fail to respond to a Complaint or Appeal within thirty (30) calendar days, and the Member has not agreed to an extension, the Member can request an independent external review and the Member will be considered to have exhausted the internal Appeals process. Also, in some instances, We may (but is not required to) agree to an independent external review even if the Member has not exhausted the First level Appeal.

The request for Independent External Review must be made to the Nevada Office of the Governor, Consumer Health Assistance within four months after the adverse benefit determination or Our final Appeal determination, whichever is later. Except as mentioned below for expedited external review Appeals, the request must be in writing on a form available through the Office of Consumer Health Assistance, which can be contacted at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

- Within 5 business days after receiving the request for external review, the Office of Consumer Health Assistance shall notify the Member, Us and other interested parties that a request for external review has been filed.
- As soon as practical, the Office of Consumer Health Assistance shall assign the Independent Review Organization.
- Within 5 business days after receiving the assignment from the Office of Consumer Health Assistance identifying the Independent Review Organization, We shall provide all

documents and materials relating to the adverse determination to the Independent Review Organization.

- Within 5 days after receiving notification from the Office of Consumer Health Assistance and the materials from Us, the Independent Review Organization will review the materials and notify the Member if additional information is needed to conduct the review.
- Additional information must be provided within 5 days after receiving the request.
- The Independent Review Organization shall forward a copy of the additional information to Us within 1 business day after receipt.
- Within 15 days of completing the review, the Independent Review Organization shall submit a copy of its determination to the Member.

When the Member or the Member's representative request Independent External Review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for independent external review. If the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's denial is eligible for independent external review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Expedited Independent External Review Appeals

An expedited review may be requested from the Office of Consumer Health Assistance when: (1) an adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the Member received Emergency Services but has not been discharged from the Facility providing the services or care; or (2) failure to proceed in an expedited manner may jeopardize the life or health of the Member or the Member's ability to regain maximum function; or (3) if the claim has been denied based upon a determination that the service or treatment is Experimental or Investigational, the Member's treating Physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated. Typically, a Member must complete a first level Appeal prior to requesting external review. However, if the adverse determination involves a denial based on a determination that the service or treatment is Experimental or Investigational and the treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, and, if the Member has a medical condition where the time to complete an expedited Appeal would seriously jeopardize the Member's life, health or ability to regain maximum function, then the Member or Member's representative can request expedited independent external review at the same time as requesting an expedited Appeal. If eligible for expedited independent external review, the Independent Review Organization assigned to the Member's case will then determine whether the independent external review should be decided before the Member's expedited Appeal.

- The Office of Consumer Health Assistance shall approve or deny a request for an expedited external review within 72 hours after it receives proof of whether the request qualifies for expedited external review.
- Upon determination that the request is eligible for an expedited external review, Office of Consumer Health Assistance shall assign an Independent Review Organization within 1 working day after approving the request.
- We shall provide all documents and information used to make the adverse determination to the Independent Review Organization within 24 hours after receiving notice from the Office of Consumer Health Assistance assigning the request.
- The Independent Review Organization must complete its review within 48 hours (unless the Member and We agree to a longer period) after receiving the assignment.

- Within 24 hours after completing the assignment, the Independent Review Organization must notify the Member, Physician and Us of its determination by telephone, followed up in writing within 48 hours.

The Member or the Member's Provider can request (orally or in writing) an expedited independent external review. Requests for expedited independent external review must be made to the Office of Consumer Health Assistance within four months of an adverse benefit determination or Our final Appeal determination, whichever is later. The Office of Consumer Health Assistance can be reached at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

When the Member or the Member's representative request independent external review, the Member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for independent external review. If the Member's claim is determined to be not eligible for independent external review, the Member will be notified of that decision. However, if the Member's denial is eligible for independent external review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Appeals Involving Independent Medical Evaluations

If We require an independent medical, dental or chiropractic evaluation to make a final determination of benefits or care, We may require the Member to submit to the independent evaluation. The evaluation will be conducted by a Physician, dentist or chiropractor who is certified to practice in the same field of practice as the primary treating Physician, dentist or chiropractor, or who is formally educated in that field.

The independent evaluation must include a physical examination of the patient, unless deceased, and a personal review of all X-rays and reports prepared by the primary treating Physician, dentist or chiropractor. A certified copy of all reports of findings must be sent to the primary treating Physician, dentist or chiropractor and the Member within 10 working days after the evaluation. If the Member disagrees with the findings of the evaluation, the Member must submit an Appeal to Us, pursuant to the procedure for binding arbitration as established by the American Arbitration Association, within 30 days after receipt of the findings of the evaluation. Upon receipt of an Appeal, We will notify the primary treating Physician, dentist or chiropractor in writing.

We will not limit or deny coverage for care related to a disputed claim that requires an independent medical evaluation while the dispute is in arbitration. However, if We prevail in the arbitration, the primary treating Physician, dentist or chiropractor may not recover any payment from Us, the Subscriber or the patient for services that the Physician, dentist or chiropractor provided to the patient after receiving written notice from Us.

Grievances

The Member may send a written Grievance to the following address within 60 days of the event:

Anthem
Quality Management Department
P.O. Box 4310
Woodland Hills, CA 91365

Our Quality Management Department will acknowledge receipt of, and investigate, the Member's Grievance. We treat each Grievance investigation in a strictly confidential manner.

Legal Action

Before a Member takes legal action on a claim decision, the Member must first follow the process outlined under the heading APPEALS in this section and the Member must meet all the requirements of this Certificate.

No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Certificate.

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

Dental Appeals

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

HMO Nevada
P.O. Box 1122
Minneapolis, MN 55440-1122

Definitions

This section defines words and terms used throughout the Certificate to help Members understand the content. Members should refer to this section to find out exactly how, for the purposes of this Certificate, a word or term is used.

Accidental Injuries: unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions which result in trauma to the body. Accidental Injuries are different from illness-related conditions.

Acupuncture Services: the treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

Acute Care: care that is provided in an office, Urgent Care setting, Emergency room or Hospital for a medical illness, accident or injury. Acute Care may be Emergency, urgent or non-urgent, but is not primarily preventive in nature.

Acute Rehabilitation Therapy: Inpatient Rehabilitation Therapy that is required for a short period of time. Acute Rehabilitation Therapy services are unrelated to acute Hospital medical or surgical care.

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.

Alcoholism Treatment Center: a Hospital, other medical facility or facility which is licensed by the health division of the department of human resources, accredited by the Joint Commission of Accreditation of Healthcare Organizations and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities. Outpatient facility and Provider office services must be performed by a Physician, licensed clinical psychologist or other Professional Provider who is properly licensed or certified to practice psychotherapy.

Allowable Expense: means 100 percent of any necessary, reasonable and customary item of expense which is covered in whole or in part (including Co-insurance, Copayment, and Deductible), as a Hospital, surgical, medical or major medical expense under this Certificate or under any Other Valid Coverage.

Alternative/Complementary Care: therapeutic practices that are not currently considered an integral part of conventional medical practice. Therapies are termed *Complementary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment. Alternative medicine includes, but is not limited to, Chinese or Ayurvedic medicine, herbal treatments, vitamin therapy, homeopathic medicine and other non-traditional remedies for treating diseases or conditions.

Ambulance: a specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.

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.

Ancillary Services: services and supplies (in addition to room services) that Hospital, Alcoholism Treatment Centers and other facilities bill for and regularly make available for the treatment of the Member's condition. Such services include, but are not limited to:

- Use of operating room, Recovery room, Emergency room, treatment rooms and related equipment.
- Drugs and medicines, biologics (medicines made from living organisms and their products), and pharmaceuticals.
- Dressings and supplies, sterile trays, casts, and splints.

- Diagnostic and therapeutic services.
- Blood processing and transportation and blood handling costs and administration.

Anesthesia: the loss of normal sensation or feeling. There are two different types of Anesthesia:

- General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or "put to sleep" for a period of time.
- Local Anesthesia causes loss of feeling or numbness in a specific area usually injected with a local anesthetic drug such as Lidocaine.

Anthem: Rocky Mountain Hospital and Medical Service, Inc., doing business as Anthem Blue Cross and Blue Shield. Also referred to as "Anthem".

Appeal: a process for reconsideration of Our decision regarding a Member's claim.

Authorization: approval of benefits for a covered procedure or service.

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

Benefit Period: the Benefit Period for this plan begins on Your Effective Date and continues until December 31 of that year. Later Benefit Periods are for a one Year period which start and end on succeeding calendar Years.

Benefit Period Maximum: the maximum number of days, visits, or dollar amount that We will pay for specific Covered Services during a Benefit Period.

Billed Charges: a Provider's regular charges for services and supplies as offered to the public generally and without any adjustment for any applicable In-Network Provider or other discounts.

Birth Abnormality: a condition that is recognizable at birth, such as a fractured arm.

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.

Care Management: a plan of Medically Necessary and appropriate health care which is aimed at promoting more effective interventions to meet Member needs and optimize care. Care Management is also referred to as case management.

Care Manager: a professional (e.g., nurse, Doctor or social worker) who works with Members, Providers and Us to coordinate services deemed Medically Necessary for the Member. A Care Manager is also referred to as a case manager.

Certificate: this document, which explains the benefits, limitations, exclusions, terms and conditions of the health coverage.

Chemotherapy: drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

Chiropractic Services: a system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and other body structures.

Chronic Rehabilitation Therapy: Inpatient Rehabilitation Therapy that is required for more than six months and may continue for the remainder of the person's life. Chronic Rehabilitation Therapy is also known as non-acute and long-term acute.

Clinical Trial: the term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Clinically Equivalent: means drugs We determine that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Co-insurance plus any Deductibles You owe. For example, if the health insurance or Certificate's allowed amount for an office visit is $100 and You've met Your Deductible, Your Co-insurance payment of 20% would be $20. Your Co-insurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Complaint: an expression of dissatisfaction with Our services or the practices of an In-Network Provider, whether medical or non-medical in nature.

Congenital Defect: a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

Consultation/Second Opinion: a service provided by another Physician who gives an opinion about the treatment of the Member's condition. The consulting Physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Copayment: a fixed amount (for example, $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to the Deductible.

Cosmetic Services: Cosmetic Services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons.

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, Co-insurance, and/or Deductibles.

Covered Services are services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto.
- Authorized in advance by Us if such Preauthorization is required by the Certificate.

Covered Services are subject to the Maximum Allowed Amount which is the maximum amount payable for Covered Services You receive, up to but not to exceed charges actually billed. If a service is not covered or if You have exceeded Your benefits for Covered Services, the Provider is not limited by the Maximum Allowed Amount and they can charge up to the billed amount.

Covered Transplant Procedures: any Medically Necessary human organ and stem cell/ bone marrow transplants and transfusions as listed as a Covered Services in this Certificate or as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative.

Custodial Care: care provided primarily to meet the personal needs of the Member. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care which does not require continuing services of specialized medical personnel.

Deductible: is the dollar amount of Covered Services, listed in the Summary of Benefits, You pay in a Benefit Period before this Certificate will pay for any remaining Covered Services during that Benefit Period.

Dental Services: services, supplies, appliances and related expenses for treatment of conditions related to the teeth or structures supporting the teeth, or for improving dental clinical outcomes.

Dentally Necessary Orthodontic Care: A service for Pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the Dental Services – Dental Care for Pediatric Members section.

Dependent: a Member of the Subscriber's family who meets the requirements listed in the MEMBERSHIP section and who has enrolled in the Certificate.

Discharge Planning: the evaluation of a Member's medical needs and arrangement of appropriate care after discharge from a facility.

Domestic Partner: Domestic Partner is a person, other than a Spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if:

- He or she has chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- Desired by their own free will to enter into a Domestic Partnership.
- The NV Secretary of State has issued a Certificate of Registered Domestic Partnership.
- He or she shares a common residence on at least a part time basis.
- He or she is mentally competent.
- He or she is at least 18 years old; is not related to the Member in any way (including by blood or adoption) that would prohibit him or her from being married under State law.
- He or she is not married to or separated from anyone else.

Durable Medical Equipment: any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

Effective Date: the date coverage under this Certificate begins.

Elective Surgery: a procedure that does not have to be performed on an Emergency basis and can be reasonably delayed. Such Surgery may still be considered Medically Necessary.

Emergency: the sudden onset of a medical condition or accident manifesting itself in acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the Member.
- Serious jeopardy to the health of an unborn child.
- Serious impairment to bodily functions.
- Serious and permanent dysfunction of any bodily organ or part

Emergency Services: with respect to an Emergency:

- A medical screening examination (as required under federal law) that is within the capability of the Emergency department of a Hospital, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency medical condition, and
- Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under federal law to Stabilize the patient.

Experimental/Investigational:

(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which We determine in its sole discretion to be Experimental or Investigational.

We 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:

- 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.
- Has been determined by the FDA to be contraindicated for the specific use.

- Is provided as part of a clinical research protocol or Clinical Trial (except where coverage for such trial is mandated by applicable law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- 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) We may still be deemed to be Experimental or Investigational. In determining whether a service is Experimental or Investigational, We will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes.
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives.
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information We consider or evaluate 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:

- Randomized, controlled, Clinical Trials published in authoritative, peer-reviewed United States medical or scientific journal.
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
- 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.
- Documents of an IRB or other similar body performing substantially the same function.
- Consent documentation(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.
- 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.
- Medical records.
- The opinions of consulting Providers and other experts in the field.

(d) We have 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.

Explanation of Benefits: also known as an EOB, a printed form sent by an insurance company to a Member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of Provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

Family Membership: a membership that covers 2 or more persons (the Subscriber and 1 or more Dependents).

Formulary: the term Formulary means a listing of Prescription Drugs that are determined by Us in its sole discretion to be designated as covered drugs. The List of approved Prescription Drugs developed by Us 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 Our other products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Us. 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 Generic Drugs means a Prescription Drug 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.

Grievance: a written Complaint about the quality of care or service received from a Provider.

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.

Hemodialysis: the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

Holistic Medicine: various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

Home Delivery (Mail Order) Pharmacy: an establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a Home Delivery (Mail Order) service upon an authorized health care professional's order.

Home Health Agency: an agency certified by the Nevada Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies. A Home Health Agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

Home Health Care: the general term for skilled nursing, Physical Therapy, Speech Therapy, Occupational Therapy, infusion therapy and other health-related services provided at home by an accredited agency.

Home Health Services: the following services provided by a certified Home Health Agency under a plan of care to eligible Members in their place of residence: professional nursing services; certified nurse aide services; Medical Supplies, equipment, and appliances suitable for use in the home; and Physical Therapy, Occupational Therapy, Speech Pathology and audiology services.

Hospice Agency: an agency licensed by the Nevada Department of Public Health and Environment to provide Hospice Care in this State. A hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, Home Health Care and follow-up bereavement services available 24 hours a day, seven days a week.

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: a health institution offering facilities, beds and continuous services 24 hours a day and meets all licensing and certification requirements of local and State regulatory agencies.

Identification Card: the card We give You that shows Your Member identification, group number, and the plan You have.

Individual Membership: a membership covering one person (the Subscriber).

In-Network Provider: A Provider that has a contract, either directly or indirectly, with Us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Pharmacy: the term In-Network Pharmacy means a Pharmacy that has an In-Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network, and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call customer service at (800) 700-2533

IUD: an acronym for intrauterine device, a device inserted into the uterus to prevent pregnancy.

Laboratory and Pathology Services: testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

Long-Term Acute Care Facility: also known as an LTAC facility, an institution that provides an array of long-term critical care services to Members with serious illnesses or injuries. Long-Term Acute Care is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable patients, extensive wound care or post operative Surgery wound Members, and low level closed head injury Members. LTAC facilities do not provide care for low intensity patient needs.

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.

Managed Care: a system of health care delivery the goal of which is to give Members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring Provider and coverage performance.

Maternity Services: services required by a Member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

- Normal vaginal delivery.
- Caesarean section delivery.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic or elective termination of pregnancy prior to viability.
- Complications of pregnancy.

Maximum Allowed Amount: the maximum amount that We will allow for Covered Services the Member receives. More information can be found in the HOW YOUR PLAN WORKS section.

Maximum Medical Improvement: a determination at Our sole discretion that no further medical care can reasonably be expected to measurably improve a Member's condition. Maximum Medical Improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

Medically Necessary: an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that We, subject to a Member's right to Appeal, as described in the COMPLAINTS, APPEALS AND GRIEVANCES section, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.

- Obtained from a Physician and/or licensed, certified or registered Provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost). It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
- Not Experimental/Investigational.
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Physician and/or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Medical Supplies: items (except Prescription Drugs required for the treatment of an illness or injury.

Medicare: a federally funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have end stage kidney disease also are eligible for Medicare benefits.

Member: the Subscriber or any Dependent who is enrolled for coverage under this Certificate.

Mental Health Condition: Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or Substance Abuse condition. It does not include autism or pervasive developmental disorders, which under State law are considered medical conditions. It includes the following conditions, which under State law are considered Severe Mental Illness: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

Minimum Essential Coverage: the term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Myotherapy: the physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones.

Occupational Therapy: the use of educational and rehabilitative techniques to improve a Member's functional ability to live independently. Occupational Therapy requires that a properly accredited occupational therapist (OT) or certified Occupational Therapy assistant (COTA) perform such therapy.

Organ Transplants: a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

Orthopedic Appliance: a rigid or semi-rigid support used to eliminate, restrict or support motion in a part of the body that is diseased, injured, weak or malformed.

Orthotic: a support or brace for weak or ineffective joints or muscles.

Other Valid Coverage: means any Other Valid Coverage with other insurers or with the same insurer. Other Valid Coverage does not include group insurance, automobile medical payments or third party liability coverage.

Other Valid Coverage may be with a Health Maintenance Organization (HMO), a Preferred Provider Organization (PPO) or another program that limits or excludes benefits if the Member does not meet the obligations for obtaining Preauthorization of care, for obtaining the proper level of care for the condition treated, or for obtaining services from Providers Authorized or recognized by Your Other Valid Coverage.

Out-of-Network Provider: A Provider that does not have an agreement or contract with Us, or Our Subcontractor(s) to give services to Our Members. You will often get a lower level of benefits when You use Out-of-Network Providers.

Out-of-Pocket Annual Maximum: a specified dollar amount of expense incurred for Covered Services in a calendar Year as listed in the Summary of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Summary of Benefits for other services that may not be included in the Out-of-Pocket Annual Maximum. When the Out-of-Pocket Annual Maximum is reached, no additional Cost-Sharing is required unless otherwise specified in this Certificate.

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 Certificate. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physical Therapy: the use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, Ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical Therapy must be performed by a Physician or registered physical therapist.

Physician (Doctor):

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform Surgery.
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.
- Doctor of Chiropractic (D.C.) legally licensed to perform the duties of a chiropractor.
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide Dental Services.

Optometrists, Clinical Psychologists (PhD), surgical chiropodists, certified nurse midwives, dentists, and certified registered nurse anesthetists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Mid-level Providers are registered nurses, clinical nurse Specialists, nurse practitioners, Physicians assistants or as determined by Us.

Preauthorization: a process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

Premium: monthly charges that the Member and/or group must pay to establish and maintain coverage.

Prescription Drug Deductible: the term Deductible means the amount of charges You must pay for any Covered Services and Prescription Drugs in a Benefit Period before any benefits are available to You under this Certificate. Your Deductible is stated in Your Summary of Benefits. The Deductible may be separate from the annual Deductibles for medical benefits and may or may not accumulate towards satisfying the medical In-Network Provider Deductibles.

Prescription Drug Maximum Allowed Amount: is the maximum amount We allow for any Prescription Drug. The amount is determined by Us using Prescription Drug costs information provided to Us by the Pharmacy Benefits Manager (PBM).

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.

Prescription Legend Drug: a medicinal substance dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution Federal law prohibits dispensing without a prescription". Compound medications that contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

Preventive Care: comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

Primary Care Physician ("PCP"): A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the plan.

Private Duty Nursing Services: services that require the training, judgment and **technical** skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by the attending Physician for the **continuous** medical treatment of the condition.

Prosthesis: a device that replaces all or part of a missing body part.

Prostate Screening: testing to identify an increased risk of prostate cancer in the absence of any abnormal symptoms.

Provider: a professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Certificate. If You have a question about a Provider not described in this Certificate please call the number on the back of Your Identification Card.

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

Qualified Health Plan Issuer or QHP Issuer: the term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

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

Radiation Therapy: x-ray, radon, cobalt, betatron, telocobalt, radioactive isotope treatment and similar treatments for malignant diseases and other medical conditions.

Reconstructive Surgery: in this Certificate Reconstructive Surgery includes those procedures that are intended to address a significant variation from normal related to Accidental Injury, disease, trauma, treatment of a disease or Congenital Defect.

Retail Health Clinic: a facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major Pharmacies or retail stores. Medical services are typically provided by Physician assistants and nurse practitioners.

Retail Pharmacy: an establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a licensed pharmacist or Home Delivery (Mail Order) service upon an authorized health care professional's order.

Second Opinion: a visit to another Professional Provider (following a first visit with a different Provider) for review of the first Provider's opinion of proposed Surgery or treatment.

Second Surgical Opinion: a mechanism used by Managed Care organizations to reduce unnecessary Surgery by encouraging individuals to seek a Second Opinion prior to specific Elective Surgeries. In some cases, the health coverage may require a Second Opinion prior to a specific Elective Surgery.

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

Service Area: the geographic area where You can get Covered Services from an In-Network Provider, as approved by State regulatory agencies.

Skilled Nursing Care Facility: an institution that provides skilled nursing care, e.g., therapies and protective supervision for uncontrolled, unstable or chronic condition Members. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide care for high intensity Member medical needs, or Members that are medically unstable.

Special Care Units: special areas of a Hospital with highly skilled personnel and special equipment to provide Acute Care with constant treatment and observation.

Specialist: a professional, usually a Physician, devoted to a specific disease, condition or body part. Examples include, but not limited to psychiatrist, orthopedist, obstetrician, gynecologist and cardiologist.

Specialty Drug List: a list of Specialty Pharmacy Drugs as determined by Us which must be obtained from Our In-Network Specialty Pharmacy affiliate and which are billed under the Pharmacy benefit.

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.

Specialty Pharmacy: a Pharmacy that is designated by Us, other than a Retail Pharmacy, Home Delivery (Mail-Order), or other Specialty Pharmacy that provides high cost, biotech drugs which are usually injected, oral, infused or inhaled and used for the treatment of acute or chronic diseases.

Specialty Pharmacy Drugs: these are high-cost, injectable, infused, oral or inhaled medications as listed on Our Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

Speech Therapy (also called Speech Pathology): services used for diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.

Spouse: a Subscriber's legal Spouse, including a Domestic Partner.

Stabilize: with respect to an Emergency, Stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Member 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.

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

Step Therapy: protocol that means that Members may need to use one type of medication before another medication will be covered.

Subscriber: the Member in whose name the membership with Us is established.

Substance Abuse: means alcoholism, drug and other Substance Abuse. Alcoholism and Substance Abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

Summary of Benefits: the document, found in the front of the Certificate, which identifies the type of coverage and Cost Shares including Deductible, Copayment and Co-insurance information.

Surgery: any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, microsurgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related Anesthesia and pre- and post-operative care, including recasting.

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 Period
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Period;
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Period; 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 Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier Three Drugs: this tier includes Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

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

Ultrasound: a radiology imaging technique that uses high frequency sound waves to see organs or the fetus in a pregnant woman.

Urgent Care: care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency).

Utilization Management: a process of integrating review of medical services and Care Management in a cooperative effort with other parties, including patients, Physicians, and other health care Providers and payers.

Utilization Review: a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, Second Opinion, certification, concurrent review, Care Management, Discharge Planning and/or retrospective review. Utilization Review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered Experimental/Investigational in a given circumstance (except if it is a specific Certificate exclusion), and review of a Member's medical circumstances when necessary to determine if an exclusion applies in a given situation.

We, Us, Our: is Anthem.

X-ray and Radiology Services: services including the use of radiology, nuclear medicine and Ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

Year: is a twelve (12) month period starting each January 1 at 12:01am Pacific Standard Time.

You and **Your:** means the Subscriber and any family Members covered under this Certificate.

Anthem BlueCross BlueShield

Subscriber and Premium Information

Issued by:

Anthem

PLAN NAME: _____

[CONTRACT CODE: _____]

SUBSCRIBER'S NAME:_____

[DEPENDENT'S NAME:_____]

[DEPENDENT'S NAME:_____]

[DEPENDENT'S NAME:_____]

SUBSCRIBER'S [RESIDENTIAL]ADDRESS: _____

MONTHLY PREMIUM RATE: _____

PREMIUM RATE EFFECTIVE DATE: _____

Please review this information carefully and if it is incorrect please inform your agent or Us immediately.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.