

Individual Contract

Anthem Silver Pathway X 3250



**Healthy Alliance Life Insurance Company
d.b.a Anthem Blue Cross and Blue Shield**

An Exclusive Provider Organization (EPO) Plan

1831 Chestnut

St. Louis, MO 63103

314-923-4444

RIGHT TO EXAMINE

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

This Contract is offered through a public marketplace operated by the State and/or federal government as part of the Patient Protection and Affordable Care Act ("Marketplace"); all enrollment changes must be made through the Marketplace by You.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance You may have.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Welcome to Anthem Blue Cross and Blue Shield!

We are pleased that You have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We've designed this Contract to give a clear description of Your benefits, as well as Our rules and procedures.

This Contract explains many of the rights and duties between You and Us. It also describes how to get health care, what services are covered, and what part of the costs You will need to pay. Many parts of this Contract are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage. You should read the whole Contract to know the terms of Your coverage.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

Many words used in the Contract have special meanings (e.g., Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated throughout this Contract. You will also see references to "We," "Us," "Our," "You," and "Your." The words "We," "Us," and "Our" mean Anthem Blue Cross and Blue Shield. The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

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



Steve Martenet

President

How to obtain Language Assistance

Anthem is committed to communicating with Our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Member Services call centers. Simply call the Member Services 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 Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also 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 Member Services number.)

Identity Protection Services

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

Contact Us

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

For information and assistance, a Member may call or write Anthem.

The telephone number for Member Services is printed on the Member's Identification Card. The address is:

Anthem Blue Cross and Blue Shield

Member Services

1831 Chestnut Street

St. Louis, MO 63103

Visit Us on-line

www.anthem.com

Hours of operation

Monday - Friday

7:30 a.m. to 6:30 p.m. MST

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State of Missouri, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Acknowledgement of Understanding

Member hereby expressly acknowledges their understanding that this Contract constitutes a contract solely between Member and Licensee, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Licensee to use the Blue Cross and/or Blue Shield Service Marks in a portion of the States Commonwealth(s) of Geography, and that Licensee is not contracting as the agent of the Association. Member further acknowledges and agrees that it has not entered into this Contract.

Based upon representations by any person other than Licensee and that no person, entity, or organization other than Licensee shall be held accountable or liable to Member for any of Licensee's obligations to Member created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Licensee other than those obligations created under other provisions of this agreement.

Delivery of Documents

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

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SCHEDULE OF COST SHARES AND BENEFITS

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

Services by Providers located outside Missouri will only be Covered Services if:

- The services are for **Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or**
- The services are approved in advance by Anthem.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Contract will allow for a Covered Service.

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

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

For a detailed explanation of how Your Deductibles and Out-of-Pocket Annual Maximums are calculated, see the “Claims Payments” section. When you receive Covered Services from an Out-of-Network Provider, you may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges.

Plan Features

Deductible	Network Member Pays	Non-Network Member Pays
Individual	\$3,250	Not Covered
Family	\$6,500	Not Covered

The individual Deductible applies to each covered family member. No one person can contribute more than his or her [their] individual Deductible amount.

Once two or more covered family members’ Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.

Coinsurance	Network Member Pays	Non-Network Member Pays
Coinsurance Percentage (unless otherwise specified)	50% Coinsurance	Not Covered

Out-of-Pocket Limit	Network Member Pays	Non-Network Member Pays
Individual	\$6,450	Not Covered
Family Includes Deductible, Copayments, and Coinsurance	\$12,900	Not Covered

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

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

Anthem can help You find a Network Provider specific to Your Plan by calling the number on the back of Your identification card.

Medical Services

Medical Services	Network Member Pays	Non-Network Member Pays
Ambulance Services		
Emergency	\$0 Copayment 50% Coinsurance	\$0 Copayment 50% Coinsurance
Non-Emergency Benefits for non-Emergency ambulance services will be limited to \$50,000 per occurrence if a Non-Network Provider is Preauthorized by Us for use.	\$0 Copayment 50% Coinsurance	Not Covered

Medical Services	Network Member Pays	Non-Network Member Pays
<p>Autism Spectrum Disorders</p> <p>Benefits for Applied Behavior Analysis are limited to Members through 18 Years of age.</p> <p>Coverage for the diagnosis and treatment of Autism Spectrum Disorders will not be subject to any greater Deductible, Coinsurance, or Copayment than is applicable to other physical health care services covered by this Plan. Any dollar or visit limits listed elsewhere in this Contract will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders. Age limits, other than the age limit for Dependent eligibility and the age limit above for Applied Behavior Analysis, also will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders.</p>	<p>Copayment/Coinsurance determined by service rendered.</p>	<p>Not Covered</p>
<p>Dental Services</p> <p>(only when related to accidental injury or for certain Members requiring general anesthesia)</p> <p>Limited to a maximum of \$3,000 per Member, per dental accident</p>	<p>Copayment/Coinsurance determined by service rendered.</p>	<p>Not Covered</p>
<p>Diabetic Equipment, Education, & Supplies</p>	<p>Copayment/Coinsurance determined by service rendered.</p>	<p>Not Covered</p>
<p>Diagnostic Services; Outpatient</p> <p>Diagnostic Laboratory and Pathology Services</p> <p>Diagnostic Imaging Services and Electronic Diagnostic Tests</p> <p>Advanced Imaging Services</p>	<p>\$0 Copayment 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>

Medical Services	Network Member Pays	Non-Network Member Pays
<p>Doctor Office Visits</p> <p>Primary Care Physician (PCP), Chiropractor Office Visits and Retail Health Clinic</p> <p>Specialty Care Physician (SCP) Office Visits</p> <p>Other Office Services Manipulation Therapy is limited to a maximum of 26 visits per Member per Calendar Year Chiropractic visits beyond the above limit require Prior Authorization from Us in order to be covered</p>	<p>Deductible does not apply; \$30 Copayment 0% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
<p>Durable Medical Equipment (medical supplies and equipment)</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Emergency Room Visits (Copayment waived if admitted) (Additional Cost-Share(s) determined based on type of service)</p>	<p>\$500 Copayment per Emergency Room Visit 50% Coinsurance</p>	<p>\$500 Copayment per Emergency Room Visit 50% Coinsurance</p>
<p>Hearing Aids Limited to a maximum of one per affected ear every 36 months</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Home Health Care Limited to a maximum of 100 visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of 82 visits per Member, per Calendar Year.</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Hospice Care</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Hospital Services</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>\$500 Copayment per admission 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p> <p>Not Covered</p>

Medical Services	Network Member Pays	Non-Network Member Pays
<p>Inpatient and Outpatient Professional Services</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation therapy services on an Outpatient basis) Limited to a maximum of 150 days, combined with Skilled Nursing Care, per Member, per Calendar Year.</p> <p>Refer to Hospital Services for Inpatient Facility Cost Shares</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>
<p>Mental Health & Substance Abuse</p> <p>Inpatient Facility (e.g., doctor and other professional Providers)</p> <p>Outpatient Facility (e.g., doctor and other professional Providers in a non-residential / Partial Hospitalization Program / Intensive Outpatient Program)</p> <p>Outpatient Office Visit (including Online Visits and intensive in-home behavioral health programs)</p> <p>Note: Two office sessions per year with a Non-Network licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or a licensed marital and family therapist, acting within the scope of such license, will be covered under this plan.</p>	<p>\$500 Copayment per admission 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p> <p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
<p>Outpatient Therapy Services</p> <p>Outpatient Habilitative and Rehabilitative therapy services (limits on Physical and Occupational therapy services listed below are not combined but separate based on determination of Habilitative service or Rehabilitative service)</p> <p>Chemotherapy, Radiation, and Respiratory</p>	<p>\$0 Copayment 50% Coinsurance</p>	<p>Not Covered</p>

Medical Services	Network Member Pays	Non-Network Member Pays
<p>Physical, Occupational, Speech and Manipulation Therapy</p> <p>Physical Therapy Limited to a maximum of 20 visits per Member, per Calendar Year. For Covered Services you receive in the office from a Physical Therapist, You will not have to pay an office visit Copayment or office visit Coinsurance that is higher than what You would pay for a Primary Care Physician.</p> <p>Occupational Therapy Limited to a maximum of 20 visits per Member, per Calendar Year. For Covered Services You receive in the office from an Occupational Therapist, You will not have to pay an office visit Copayment or office visit Coinsurance that is higher than what You would pay for a Primary Care Physician.</p> <p>Speech Therapy Unlimited visits per Member, per Calendar Year.</p> <p>Cardiac Rehabilitation Limited to a maximum of 36 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply.</p> <p>Pulmonary Rehabilitation Limited to a maximum of 20 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.</p>		
<p>Preventive Care Services Network services required by law are not subject to Deductible. Immunizations for children prior to the 6th birthday are covered in full from either Network or Non-Network Providers.</p>	<p>\$0 Copayment 0% Coinsurance</p>	<p>Not Covered</p>

Medical Services	Network Member Pays	Non-Network Member Pays
Prosthetics Prosthetic devices, their repair, fitting, replacement and components	\$0 Copayment 50% Coinsurance	Not Covered
Skilled Nursing Care Limited to a maximum of 150 days, combined with Inpatient Physical Medicine and Rehabilitation, per Member per Calendar Year.	\$0 Copayment 50% Coinsurance	Not Covered
Surgery Ambulatory Surgical Center	\$0 Copayment 50% Coinsurance	Not Covered
Temporomandibular and Craniomandibular Joint Treatment	Copayment/Coinsurance determined by service rendered.	Not Covered
Transplant Human Organ & Bone Marrow/Stem Cell/Cord Blood Network only - Transplant Transportation and Lodging \$10,000 maximum benefit limit per transplant Unrelated Donor Search - \$30,000 maximum benefit limit per transplant	Copayment/Coinsurance determined by service rendered.	Not Covered
Urgent Care Center (Additional Cost-Share(s) determined based on type of service)	\$75 Copayment per Urgent Care Visit 50% Coinsurance	\$75 Copayment per Urgent Care Visit 50% Coinsurance

Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 In-Network Pharmacy. If You get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When You go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other In-Network Providers.

Level 2 In-Network Pharmacies. When You go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 In-Network Pharmacy.

Retail Pharmacy Prescription Drugs	Network Member Pays		Non-Network Member Pays
	Level 1 Pharmacy	Level 2 Pharmacy	
Tier 1	Deductible does not apply; \$10.00 Copayment 0% Coinsurance	Deductible does not apply; \$20.00 Copayment 0% Coinsurance	Not Covered
Tier 2	Deductible does not apply; \$50.00 Copayment 0% Coinsurance	Deductible does not apply; \$60.00 Copayment 0% Coinsurance	Not Covered
Tier 3	\$0 Copayment 50% Coinsurance	\$0 Copayment 50% Coinsurance	Not Covered
Tier 4	\$0 Copayment 50% Coinsurance	\$0 Copayment 50% Coinsurance	Not Covered

Notes:

Retail Pharmacy is limited to a 30-day supply per prescription.

Specialty Drugs must be purchased from Anthem’s Specialty Preferred Provider.

Coverage is limited to those Drugs listed on Our Prescription Drug List (Formulary).

You will be responsible for only one Copayment/Coinsurance for a covered Prescription Drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the Prescription Order.

Mail Order Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 1 (90-day supply)	Deductible does not apply; \$25.00 Copayment 0% Coinsurance	Not Covered
Tier 2 (90-day supply)	Deductible does not apply; \$150.00 Copayment 0% Coinsurance	Not Covered
Tier 3 (90-day supply)	\$0 Copayment 50% Coinsurance	Not Covered
Tier 4 (30-day supply)	\$0 Copayment 50% Coinsurance	Not Covered
<p>Notes:</p> <p>Specialty Drugs must be purchased from Anthem’s Specialty Preferred Provider and are limited to a 30-day supply.</p> <p>Coverage is limited to those Drugs listed on our Prescription Drug List (Formulary).</p> <p>You will be responsible for only one Copayment/Coinsurance for a covered Prescription Drug if the required single dosage is unavailable and/or a combination of dosage amounts is needed to fill the Prescription Order.</p>		
Orally Administered Cancer Chemotherapy	As required by Missouri law, You will not have to pay a Cost-Share (e.g., Copayment, Deductible, or Coinsurance) for the orally administered cancer chemotherapy Drugs You get at a Retail or Home delivery (Mail Order) Pharmacy that is higher than the Cost-Share You pay for intravenously-administered or injected chemotherapy covered in a doctor’s office or other outpatient setting. These drugs will not be subject to any prior authorization, dollar limit or out of pocket expenses that would not apply to the intravenously-administered or injected anti-cancer medications.	

Pediatric Dental Services

The following pediatric dental services are covered for Members until the end of the month in which they turn 19.

Covered Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost Shares and Benefits.

Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

Pediatric Dental Care	Network Member Pays	Non-Network Member Pays
Diagnostic and Preventive Services	0% Coinsurance	Not Covered
Basic Restorative Services	50% Coinsurance	Not Covered
Oral Surgery Services	50% Coinsurance	Not Covered
Endodontic Services	50% Coinsurance	Not Covered
Periodontal Services	50% Coinsurance	Not Covered
Major Restorative Services	50% Coinsurance	Not Covered
Prosthodontic Services	50% Coinsurance	Not Covered
Dentally Necessary Orthodontic Care Services	50% Coinsurance	Not Covered

Pediatric Vision Services

The following vision care services are covered for members until the end of the month in which they turn 19. To get the Network benefit You must use a Blue View Vision Provider. Visit our website or call Us at the number on your ID card if you need help finding a Blue View Vision provider.

Please see Pediatric Vision Care in the “What is Covered” section for a more information on pediatric vision services.

Covered vision services are **not** subject to the Calendar Year Deductible.

Covered Vision Services	Network Member Pays	Non-Network Reimbursement
Routine Eye Exam Covered once per Calendar Year per Member	\$0 Copayment	Not Covered
Standard Plastic or Glass Lenses One set of lenses covered per Calendar Year per Member.		
Single Vision	\$0 Copayment	Not Covered
Bifocal	\$0 Copayment	Not Covered
Trifocal	\$0 Copayment	Not Covered
Standard Progressive	\$0 Copayment	Not Covered
Lenticular	\$0 Copayment	Not Covered
Additional Lens Options Covered lenses include the following lens options at no additional cost when received from Network Providers: factory scratch coating, UV coating, standard polycarbonate, standard photochromic, gradient tinting, standard anti-reflective coating, glass-grey #3 prescription sunglasses.		
Frames (Formulary) One frame covered per Calendar Year per Member.	\$0 Copayment	Not Covered
Contact Lenses (Formulary) Elective or non-elective contact lenses are covered once per Calendar Year per Member.		
Elective (conventional and disposable)	\$0 Copayment	Not Covered
Non-Elective	\$0 Copayment	Not Covered
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		

Covered Vision Services	Network Member Pays	Non-Network Reimbursement
<p>Low Vision Low vision benefits are only available when received from Blue View Vision Providers.</p>		
<p>Comprehensive Low Vision Exam</p>	<p>\$0 Copayment</p>	<p>Not covered</p>
<p>Optical/Non-optical aids/Supplemental Testing. Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year per Member.</p>	<p>\$0 Copayment</p>	<p>Not covered</p>

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.

HOW YOUR COVERAGE WORKS

Network Providers are the key to providing and coordinating Your health care services. Benefits are provided when You obtain Covered Services from Providers located in the State of MO; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Provider. Services You obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Emergency ambulance services, or as an Authorized Service. Contact a PCP, SCP, other Network Provider, or Us to be sure that Prior Authorization and/or Precertification has been obtained – except no Prior Authorization/Precertification is required for Emergency Care, Urgent Care, Emergency ambulance services, or care that We approve as an Authorized Service.

Network Services and Benefits

If Your care is rendered by a PCP, SCP, or another Network Provider, benefits will be paid at the Network level and You will not be financially responsible for any Covered Services that We determine are not Medically Necessary. However, regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of physicians. We determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You may Appeal this decision. See the “Complaint and Appeals Procedures” section of this Contract.

- **Network Providers** - include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the physician who may provide, coordinate, and arrange Your health care services. SCPs are Network physicians who provide specialty medical services not normally provided by a PCP.
- **For services rendered by Network Providers:**
 - You will not be required to file any claims for services You obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance and/or Copayments. You may be billed by Your Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Contract.
 - When required, prior approval of benefits is the responsibility of the Network Provider. See the “Requesting Approval for Benefits” section.

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

How to Find a Provider in the Network

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

- See Your Plan’s directory of Network Providers at www.anthem.com, which lists the doctors, Providers, and Facilities that participate in this Plan’s network.
- Call Member Services to ask for a list of doctors and Providers that participate in this Plan’s network, based on specialty and geographic area.
- Check with Your doctor or Provider.

If You need details about a Provider’s license or training or help choosing a doctor who is right for You, call the Member Services 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.

Dental Providers

You must select a participating dentist to receive dental benefits. Please call Our Member Services department at (800) 627-0004 for help in finding a participating dentist or visit Our website at www.anthem.com/mydentalvision. Please refer to Your ID card for the name of the dental program that participating providers have agreed to service when You are choosing a participating dentist.

Not Liable for Provider Acts or Omissions

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

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

Identification Card

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

Continuity of Care

If Your Network Provider leaves Our network because We have terminated their contract without cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive Network Benefits. "Active treatment" includes:

1. An ongoing course of treatment for a life-threatening condition.
2. An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits).
3. The second or third trimester of pregnancy and through the postpartum period.
4. An ongoing course of treatment for a health condition for which the physician or health care Provider attests that discontinuing care by the current physician or Provider would worsen Your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for Mental Health and Substance use disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You or Your doctor should contact Member Services for details. Any decision by Us regarding a request for Continuity of Care is subject to the Appeals Process.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

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

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you choose a PCP, make an appointment with your PCP. During this appointment, get to know your PCP and help your PCP get to know you. At your first appointment, talk to your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns you have.

It is important to note, if you have not established a relationship with your PCP, they may not be able to effectively treat you. 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.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Contract. Utilization Review aids in the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate.

If You have any questions about the information in this section, You may call the Member Service phone number on the back of Your Identification Card.

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

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

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
 - **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain Services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Contract.

For admissions following Emergency Care, 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 required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.
 - **Predetermination** – An optional, voluntary Pre-Service Review request for a benefit coverage determination for a 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 or is Experimental/Investigative as those terms are defined in this Contract.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification or did not have a Predetermination review performed. Post-service reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed or ask for a Predetermination, even though it is not required. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor (“requesting Provider”) will get in touch with Us to ask for a Precertification or Predetermination review. However, You may request a Precertification or Predetermination, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 Years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsible Party	Comments
Network	Provider	<ul style="list-style-type: none"> • The Provider must get Precertification when required.
Non-Network	Member	<p>Member has no benefit coverage for a Non-Network Provider unless:</p> <ul style="list-style-type: none"> • The Member gets approval to use a Non-Network Provider before the service is given; or • The Member requires an Emergency Care admission (see note below). <p>Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.</p>
BlueCard Provider	Member (Except for Inpatient admissions)	<ul style="list-style-type: none"> • Member must get Precertification when required (call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.
<p>Note: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.</p>		

How Decisions are Made

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

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

If You are not satisfied with Our decision under this section of Your benefits, please refer to the “If You Have a Complaint or an Appeal” section to see what rights may be available to You.

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision	Timeframe Requirement for Notification
Precertification Requests		
Pre-service Urgent	36 hours from the receipt of request, including 1 business day If the Member receives an Emergency service that requires immediate post evaluation or post stabilization services, We will provide an authorization decision within 60 minutes of receiving the request; if the authorization decision is not made within 30 minutes, such services shall be deemed approved.	For approval determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within 2 business days of the decision. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within 1 business day of the decision.
Pre-service Non-Urgent	36 hours from the receipt of the request, including 1 business day	

Concurrent / Continued Stay Review Urgent	1 business day from the receipt of the request	For approval determination, We will notify the Provider by telephone or electronically within 1 business day of the decision and notify the Member or Member representative and Provider by written or electronic means within 1 business day of the telephonic or electronic notification. For Adverse Determination, We will notify the Provider by telephone or electronically within 24 hours of the decision and notify the Member or Member representative and Provider by written or electronic means within 1 business day of the telephonic or electronic notification. The service will continue without Member liability until the Member has been notified of the determination.
Concurrent / Continued Stay Review Non-Urgent	1 business day from the receipt of the request	
Post-service Review	10 business days from the receipt of the request	We will notify the Member by written means of the determination within 10 business days of the determination.
Predetermination Review		
Pre-service Urgent	36 hours from the receipt of request, including 1 business day	
Pre-service/ Non- Urgent	36 hours from the receipt of the request, including 1 business day	
Concurrent / Continued Stay Review Urgent	1 business day from the receipt of the request	
Concurrent / Continued Stay Review Non-Urgent	1 business day from the receipt of the request	

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

If We authorize medical services, We will not subsequently retract Our authorization after the services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless:

Such authorization is based on a material misrepresentation or omission about the Member's health condition or the cause of the health condition; or The Member's coverage terminates before the services are provided.

Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line pre-certification list, or contacting the Member Services number on the back of Your ID Card.

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

Health Plan Individual Case Management

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

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

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

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

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

WHAT IS COVERED

This section describes the Covered Services available under this Contract. Covered Services are subject to all the terms and conditions listed in this Contract, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements.

Please read the following sections of this Contract for more information about the Covered Services described in this section:

- Schedule of Cost-Shares and Benefits – for amounts You need to pay and benefit limits
- Requesting Approval for Benefits – for details on selecting Providers and services that require pre-authorization
- What is Not Covered (Exclusions) – for details on services that are not covered

Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to Your claims. For example, if You have Inpatient surgery, benefits for Your Hospital stay will be described under "Hospital Services; Inpatient Hospital Care" and benefits for Your doctor's services will be described under "Inpatient Professional Services". As a result, You should read all sections that might apply to Your claims.

You should also know that many Covered Services can be received in several settings, including a doctor's office, an Urgent Care Center, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay.

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following are met:

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

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

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

Ambulance services or Emergency medical response agencies that are licensed by the State of Missouri to provide the above Covered Services will be paid directly by the Plan.

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

Ground Ambulance

Services are subject to Medical Necessity review by the Plan.

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 the Plan. The Plan retains the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation.

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

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Services

Benefits for Applied Behavior Analysis are limited to Members through 18 Years of age. Coverage for the diagnosis and treatment of autism spectrum disorders will not be subject to any greater Deductible, Coinsurance, or Copayment than is applicable to other physical health care services covered by this Contract. Any dollar or visit limits listed elsewhere in this Contract will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders. Age limits, other than the age limit for Dependent eligibility and the age limit above for Applied Behavior Analysis, also will not apply to services rendered in the diagnosis or treatment of Autism Spectrum Disorders. The benefits below are available for the treatment of Autism Spectrum Disorders.

The following definitions apply to this section only:

- Applied Behavior Analysis – the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.
- Autism Service Provider – any person, entity, or group that provides diagnostic or treatment services for Autism Spectrum Disorders who is licensed or certified by the State of Missouri, or any person who is licensed under chapter 337 as a Board Certified Behavior Analyst by the Behavior Analyst Certification Board or licensed under chapter 337 as an Assistant Board Certified Behavior Analyst.
- Autism Spectrum Disorders – a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- Line Therapist – an individual who provides supervision of an individual with an autism diagnosis and other neurodevelopmental disorders pursuant to the prescribed treatment Plan, and implements specific behavioral interventions as outlined in the behavior Plan under the direct supervision of a licensed Behavior Analyst;

Benefits for the Diagnosis and Treatment of Autism Spectrum Disorders

Benefits include Medically Necessary Covered Services to diagnose and treat Autism Spectrum Disorders when prescribed or ordered for a Member diagnosed with an Autism Spectrum Disorder by a licensed physician or licensed Psychologist.

Covered Services include the following:

- Diagnosis of Autism Spectrum Disorders – Medically Necessary assessments, evaluations, or tests in order to diagnose whether an individual has an Autism Spectrum Disorder;
- Habilitative or rehabilitative care – Professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis from a licensed Autism Service Provider or Line Therapist under the direct supervision of a licensed Behavioral Analyst, which are necessary to develop the functioning of the Member;
- Psychiatric care – Direct or consultative services provided by a licensed Psychiatrist;
- Psychological care – Direct or consultative services provided by a licensed Psychologist;
- Therapeutic care – Services provided by licensed Speech Therapists, Occupational Therapists, or Physical Therapists;
- Equipment – Medically Necessary equipment for the treatment of Autism Spectrum Disorders;
- Pharmacy care – Prescription Drugs used to address symptoms of an Autism Spectrum Disorder prescribed by a licensed physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the Prescription Drugs if those Prescription Drugs are covered by this Contract. Pharmacy benefits will be reimbursed under the Prescription Drug benefit.

We may require your Provider to submit a treatment Plan to Us in order to determine when benefits for Applied Behavior Analysis (ABA) should be available. We will not require this more than once every six

months for Outpatient ABA services, unless your physician or Psychologist agrees to provide a treatment Plan more frequently.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a) The National Institutes of Health.
 - b) The Centers for Disease Control and Prevention.
 - c) The Agency for Health Care Research and Quality.
 - d) The Centers for Medicare & Medicaid Services.
 - e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer Clinical Trials provided by i-iii below.
 - 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.

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

All 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.

Dental Services

Accident Related Dental Services

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

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

- Oral examinations;

- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

General Anesthesia

Benefits are provided only for the administration of general anesthesia and for both Facility and professional charges occurring in connection with dental services, services, regardless of age, when prior authorization for an Inpatient dental care procedure is approved by Us. In addition, and as required by law, benefits for the administration of general anesthesia, including Facility and professional charges, are provided for the following Members regardless of whether the services are provided in a participating hospital or surgical center or office:

- A Member through the age of four;
- A Member who is severely disabled; and
- A Member who has a medical or behavioral condition that requires Hospitalization or general anesthesia when dental services are provided.

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

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

Diabetes Services

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

Diabetes Self-Management Training is covered for an individual with insulin Dependent diabetes, noninsulin Dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

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

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

Covered Services also include all physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances". Screenings for gestational diabetes are covered under "Preventive Care Services".

Diagnostic Services Outpatient

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist.

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Doctor (Physician) Visits

Covered Services include:

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

After Hours Care for medical 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.

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 Care Services" benefit described later in this section.

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.

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Online Visits when available in your area. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or doctor to doctor discussions. For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse Services" section.

Telehealth Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Contract. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Service at the number on the back of your identification card.

Chiropractic office visits for medical care including examination, diagnosis, adjustment, manipulation and treatment both in Inpatient and Outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board.

Emergency Care Services

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

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 or behavioral health 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 or the health of another person in serious danger or, for a pregnant woman, placing the woman’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. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions. “Emergency Service” means a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to, health care services that are provided in a licensed Hospital's emergency facility by an appropriate Provider.

Emergency Care means a medical or behavioral health exam done in the Emergency Department of a Hospital, and includes Emergency Services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and Emergency Services required to stabilize the patient.

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

To provide such medical treatment that no material deterioration of the condition is likely to result or occur before an individual may be transferred.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from a Non-Network Provider, Covered Services will not be available unless we agree to cover them as an Authorized Service.

Habilitative Services

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

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an Outpatient basis. Services must be prescribed by a doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Visits by a licensed health care professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide.
- Infusion Therapy; refer to Other therapy services, later in this section for more information
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Medical supplies
- Durable medical equipment
- Therapy services (except for Manipulation Therapy, which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost Shares and Benefits for Home Care Services apply when therapy services are rendered in the home.
- Private duty nursing in the home.

Hospice Care

Hospice care is a coordinated Plan of home, Inpatient and/or Outpatient care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients.

Covered Services and supplies are those 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.

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

In order to receive Hospice benefits (1) Your physician and the Hospice medical director must certify that You are terminally ill and generally have less than 12 months to live, and (2) Your physician must consent to Your care by the Hospice and must be consulted in the development of Your treatment Plan. The Hospice must maintain a written treatment Plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these

additional Covered Services, which are described in other parts of this certificate, are provided as set forth in other parts of this certificate.

Hospital Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two or more beds.
- A private room. The most the Plan 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.
- 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.
- Treatment for a health problem by a doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two or more doctors during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate doctors.
- A personal bedside exam by another doctor when asked for by Your doctor. 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.

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Center,
- Mental Health and Substance Abuse Facility,
- Other Facilities approved by us

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

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- 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.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent
- Prenatal, postnatal, and postpartum services
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us
- Post-discharge care consisting of a minimum of two visits, with at least one being in the home, by a registered professional nurse or a physician. Services shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, and performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Note: Under federal and state law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after 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.

Please see Continuity of Care in the "How Your Coverage Works" section regarding a request to continue to see the same Provider for services.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for further details.

Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for more details.

Sterilization Services

Benefits for men and women include sterilization services. Reversals of sterilizations are not covered unless resulting from an illness or injury. Sterilizations for women are covered under the "Preventive Care Services" benefit.

Abortion Services

Coverage includes benefits for abortions, for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Plan 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, except when damage is due to neglect. Benefits also include 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.

Hearing Supplies

Benefits are available for Members who are certified as deaf or hearing impaired by either a physician or licensed audiologist. Covered Services include:

- Hearing Aids – Any wearable, non disposable instrument or device designed to aid or compensate for impaired human hearing.
- Cochlear implants – A Surgically implanted device that allows hearing.

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

Covered Services must be ordered by a physician and 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 Plan 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:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by law;

- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment.

Medical and Surgical Supplies

Your Plan 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.

Diabetic Equipment and Supplies

Your Plan includes coverage for diabetic equipment and supplies (insulin pump, blood glucose monitor, lancets and test strips, etc.)

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Phenylketonuria (PKU)

Covered Services include PKU formula and low protein modified food products for the treatment of phenylketonuria or any inherited diseases of amino acids and organic acids. Low protein modified food products are foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic disease. Low protein foods do not include foods that are naturally low in protein.

Mental Health and Substance Abuse Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute Mental Disorders and Substance Abuse Conditions. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. For the purposes of this section the Joint Commission is abbreviated as JCAHO and the Commission on Accreditation of Rehabilitation Facilities is abbreviated as CARF.

Covered Services include the following:

- Inpatient Services in a JCAHO-accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Eating Disorder Treatment including Inpatient Services, Outpatient Services, Residential Treatment and counseling.
- Outpatient Services including in-home and office visits and treatment in an Outpatient department of a Hospital or JCAHO-accredited or CARF-accredited Outpatient Facility, such as non-Residential Treatment Facilities, Partial Hospitalization Programs and Intensive Outpatient Programs.
- Online Visits when available in Your area. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by JCAHO or CARF. 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.

Note: Two office sessions per year with a Non-Network licensed psychiatrist, licensed psychologist, licensed professional counselor, licensed clinical social worker, or a licensed marital and family therapist, acting within the scope of such license, will be covered under this Plan.

Preventive Care Services

Preventive care services include screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable State law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - Breast cancer,
 - Cervical cancer,
 - High blood pressure,
 - Type 2 Diabetes Mellitus,
 - Cholesterol,
 - Child or adult obesity.
 - Colorectal cancer,
 - Testing of pregnant women and other Members for lead poisoning;
 - Routine prostate exam and prostate specific antigen testing in accordance with current American Cancer Society guidelines;
 - Screening mammograms for asymptomatic women, including any woman whose doctor has recommended a mammogram because of a prior family history of breast cancer.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - Contraceptive coverage includes Generic Drugs and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be

- covered, as preventive care benefits when medically necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail order) Pharmacy".
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per Calendar Year or as required by law.
 - Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
- Counseling
 - Prescription Drugs
 - Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
 - Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
- Aspirin
 - Folic acid supplement
 - Vitamin D supplement
 - Bowel preparations

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

You may call Member Services at the number on Your Identification Card for more details about these services or view the federal government's web sites:

- <https://www.healthcare.gov/what-are-my-preventive-care-benefits>
- <http://www.ahrq.gov>
- <http://www.cdc.gov/vaccines/acip/index.html>

Rehabilitative Services

Health care services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services 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 Facility. Custodial Care is not a Covered Service.

Surgery

Your Plan covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

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

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

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.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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 fixed or removable appliances that involve movement or repositioning of the teeth (braces), repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services Outpatient

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve Your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- **Occupational therapy** – Treatment to restore a physically disabled person’s ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person’s job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor’s office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to You through an I.V. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Manipulation Therapy** – Includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Physical Medicine and Rehabilitation Services

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

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

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

- Admission to a Hospital mainly for physical therapy;
- Long-term rehabilitation in an Inpatient setting.

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

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

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 Contract.

Covered Transplant Procedure

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

Unrelated Donor Searches

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

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowed 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 Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility. Services received from a Non-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, You will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. 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, Network Transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are Network Transplant Providers. Contact the Member Services 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 prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA

testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

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

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

The human organ and bone marrow/stem cell/cord blood transplant 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.

Urgent Care Services

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

- X-ray services;
- Care for broken bones
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Prescription Drugs

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility and are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs that You inject or get through Your Pharmacy benefit (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

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

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

- quantity, dose, and frequency of administration;
- specific clinical criteria (including but not limited to requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- specific Provider qualifications (including but not limited to REMS certification (Risk, Evaluation and Mitigation Strategies));
- step therapy requiring one drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of an Anthem Prescription Drug List (a Formulary developed by Anthem which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.)
- Benefits are also available for any Prescription Drug approved by the FDA to treat HIV infection or HIV related illness. This includes new Drugs that are in, or have finished, a phase 3 clinical investigation. It also includes Drugs prescribed and given to You as part of an approved FDA treatment protocol.

Precertification

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

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

Please refer to the section "Requesting Approval for Benefits" for more details.

If Precertification is denied You have the right to file a Grievance as outlined in the "If You have a Complaint or an Appeal" section of this Contract.

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the

Network Provider must have signed a Designated Pharmacy Provider Agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

We may also require You to use a Designated Pharmacy Provider to obtain Specialty Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve Our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in Our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Non-Network level.

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

Therapeutic Substitution

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

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

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

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

Prescription Drug Benefits

Prescription Drug benefits may require Prior Authorization to determine if Your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for Us to decide benefits.

Prior Authorization

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

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

- quantity, dose, and frequency of administration;

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

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

Anthem may, from time to time, waive, enhance, change or end certain Prior Authorization and/or alternate benefits, if in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If Prior Authorization is denied You have the right to file a Grievance as outlined in the “If You have a Complaint or an Appeal” section of this Contract.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM’s Home Delivery Pharmacy;
- Specialty Drugs;
- Self-Administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the “Prescription Drugs Administered by a Medical Provider” benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for more details.
- Flu Shots (including administration).
- Early refills of prescription eye drops when authorized by your Provider, as long as, Anthem is notified.

Where You Can Get Prescription Drugs

Network Pharmacy

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

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, We may

require You to select a single Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single Network Pharmacy. We will contact You if We determine that use of a single Network Pharmacy is needed and give You options as to which Network Pharmacy You may use. If You do not select one of the Network Pharmacies We offer within 31 days, We will select a single Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the “If You have a Complaint or an Appeal” section of this Contract.

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

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 Network Pharmacy. If You get Covered Services from any other Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 Network Pharmacies. When You go to Level 1 Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other Network Providers.

Level 2 Network Pharmacies. When You go to Level 2 Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 Network Pharmacy.

Specialty Pharmacy

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

When You use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your doctor to get Prior Authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your prescription.

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

When You Order Your Prescription Through the Specialty Preferred Provider

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

Specialty Pharmacy Program

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

If You order Your specialty drug through the Specialty Preferred Provider and it does not arrive, if Your physician decides that it is medically necessary for You to have the drug immediately, We will authorize

an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow You to get an Emergency supply of medication from a participating Pharmacy near You. A Member Services representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain Drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written prescriptions from Your Doctor or have Your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when You ask for a prescription or refill.

Maintenance Medication

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

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

When using Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the mail order program, You can call Member Services toll-free at 1-800-281-5524.

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

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

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program Member Services department at 1-866-274-6825 for availability of the Drug or medication.

What You Pay for Prescription Drugs

Tiers

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

To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 Network Pharmacy.

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

- **Tier 3** Drugs have a higher Coinsurance or Copayment than those in tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 4** Drugs have a higher Coinsurance or Copayment than those in tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

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

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

Prescription Drug List

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

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

If You have a question regarding whether a Drug is on the Prescription Drug Formulary, please refer to Our website at www.anthem.com.

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.

This Plan limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem BCBS products. Benefits may not be covered for certain drugs if they are not on the Prescription Drug list. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem BCBS. We may add or delete Prescription Drugs from this Formulary from time to time. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage. You will be notified electronically, or in writing upon Your request, at least 30 days prior to any deletions, other than generic substitutions, to the Formulary. A description of the prescription drugs that are listed on this Formulary is available in writing 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.

Drug Utilization Review

If there are patterns of over utilization or misuse of Drugs, We will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, You must use a certain amount of Your prescription before it can be refilled. In some cases We may let You get an early refill. For example, We may let You refill Your prescription early if it is decided that You need a larger dose. We will work with the Pharmacy to decide when this should happen.

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

Half-Tablet Program

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

Therapeutic Substitution

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

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at a 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 ID card or log on to the Member website at www.anthem.com.

Special Programs

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

Pediatric Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is medically or dentally necessary. The only exception is when You get orthodontic care — We do review those services to make sure they're appropriate.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it's best to go over a care or treatment Plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for Members until the end of the month in which they turn 19. All Covered Services are subject to the terms, limitations, and exclusions of this Contract. See the "Schedule of Cost Shares and Benefits" for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Two oral exams are covered every 12 months.

Radiographs (X-rays): Here are ones that are covered:

- Bitewings – 2 sets per 12 month period.
- Full mouth (also called complete series) – 1 time per 60 month period.
- Panoramic – 1 time per 60 months.
- Periapicals and occlusals.
- 2D Cephalometric radiographic image
- Oral/facial images (includes intra and extraoral images).

Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.

Diagnostic Casts

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if Member is 13 or Younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 month period.

Sealants or Preventive Resin Restorations. Any combination of these procedures is covered 1 time per tooth per 36 months.

Space Maintainers and Recement Space Maintainers

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Consultations. Covered when given by a provider other than Your treating dentist.

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kinds of fillings covered under this Plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.

- **Composite Resin.** These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If You choose to have a composite resin filling placed on a back tooth, We will pay up to the Maximum Allowed Amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable Deductible or Coinsurance.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth

- Pulpal therapy
- Therapeutic pulpotomy

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.

Pre-fabricated or Stainless Steel Crown. Covered 1 time per 60 months for Members through the age of 14.

Pin Retention

Therapeutic Drug Injection

Protective Restoration

Partial pulpotomy for apexogenesis. Covered on permanent teeth only

Resin Infiltration/smooth surface. Covered 1 time per 36 months

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.

Treatment of complications. (Post-surgical) unusual circumstances.

Endodontic Services

Endodontic Therapy. The following will be covered for permanent teeth only:

- Root canal therapy.
- Root canal retreatment.

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation per root
- Hemisection

Periodontal Services

Full Mouth Debridement. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered once per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 month period. Covered for permanent teeth only.

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery

- Bone replacement graft

The following complex surgical periodontal care services are not subject to the benefit frequency stated above.

- Pedicle soft tissue graft.
- Free soft tissue graft
- Subepithelial connective tissue graft.
- Soft tissue allograft

Crown Lengthening

Oral Surgery Services

Complex Surgical Extractions. Surgical removal of 3rd molars are covered only when symptoms of oral pathology exists.

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

Other Complex Surgical Procedures

- Alveoloplasty
- Removal of exostosis – per site

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral and extroral soft tissue).
- Collection and application of autologous product. Covered 1 time per 36-month period.
- Excision of pericoronal gingiva.
- Tooth reimplantation (accidentally evulsed or displaced tooth).
- Suture of recent small wounds up to 5 cm and complicated sutures.
- Bone replacement graft for ridge prevention – per site.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same Maximum Allowed Amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable Deductible and Coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same Maximum Allowed Amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable Deductible and Coinsurance.

Onlays (metallic). Covered 1 time per 60 months. Onlays made of porcelain or composite will be paid up to the same Maximum Allowed Amount for an onlay made for metallic. You are responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Permanent Crowns. Covered 1 time per 60 months.

Recement an Inlay, Onlay or Crown. Covered 6 months after initial placement.

Inlay, Onlay, Crown and Veneer Repair. The narrative from Your treating dentist must support the procedure.

Implant Crowns. See the implant procedures description under Prosthodontic Services.

Core Build Up including pins.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth every 60 months.

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

Prosthetic Services

Dentures (including immediate) and Partials (removable prosthetic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If You have an existing denture or partial, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. Immediate partials are not covered.

Overdentures (Complete and Partial Upper and Lower). We will pay up to the Maximum Allowed Amount for an upper and lower complete denture or partial denture. If you still choose to have an overdenture, you will have to pay the difference any Deductible and/or Coinsurance for the covered benefit.

Bridges (fixed prosthetic services). Covered 1 time per 60 months. The Plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the Plan may cover a partial denture instead of the bridge. If You still choose to get the bridge, You will be responsible to pay the difference in cost, plus any applicable Deductible and Coinsurance.

Tissue Conditioning

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Repairs and Replacement of Broken Clasps

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance and the narrative from the treating dentist supports the service.

Denture Adjustments**Partial and Bridge Adjustments****Recementation of Bridge (fixed prosthetic)**

Single Tooth Implant Body, Abutment and Crown. Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. It's recommended that You get a pretreatment estimate, so You fully understand the treatment and cost before having implant services done.

Implant Supported Fixed and Removable Prosthetics (crowns, dentures, partials and bridges). Covered once per 60 months.

Add Tooth or Clasp to Existing Partial Denture**Orthodontic Care**

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to Your dental provider about getting a pretreatment estimate for Your orthodontic treatment Plan, so You have an idea upfront what the treatment and costs will be. You or Your dental provider should send it to Us so We can help You understand how much is covered by Your benefits.

Dentally Necessary Orthodontic Care. This Plan will only cover orthodontic care that is dentally necessary — at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with Your biting function

- Overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite
- The position of Your jaw or teeth impairs Your ability to bite or chew
- On an objective, professional orthodontic severity index, Your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Pre-Orthodontic Treatment Exams. Periodic visits with Your dentist to establish when orthodontic treatment should begin.
- Periodic Orthodontic Treatment Visits.
- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures give for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of Your treatment. In order for Us to continue to pay for Your orthodontic care You must have continuous coverage under this Contract.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Contract ends.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin coverage under this Contract, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that You are given while covered under this Contract. We will not pay for any portion of Your treatment that was given before Your Effective Date under this Contract.

What Orthodontic Care Does NOT Include. The following is not covered as part of Your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or Outpatient Hospital expenses, unless covered by the medical benefits of this Contract.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get network benefits, use a Blue View Vision eye care Provider. For help finding one, try “Find a Doctor” on Our website, or call Us at the number on Your ID card.

Routine Eye Exam

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

Eyeglass Lenses

Standard plastic (CR39) or glass eyeglass lenses up to 55mm are covered, whether they’re single vision, bifocal, trifocal (FT 25-28), progressive or lenticular.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the “Schedule of Cost Shares and Benefits” for the list of covered lens options.

Frames

Your Blue View Vision Provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge — and which ones will cost You more.

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given Year. Your Blue View Vision Provider will have a collection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge – and which ones will cost You more.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
- High ametropia exceeding -12D or +9D in spherical equivalent
- Pathological myopia, aphakia, anisometropia (of 3D or more), aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses
- If contact lenses result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Note: We will not pay for non-elective contact lenses for any Member who’s had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when You have a significant loss of vision, but not total blindness. Your plan covers services for this condition when You go to a Blue View Vision eye care Provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

In this section You will find a review of items that are not covered by Your Plan. 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 Plan.

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

Services rendered by Providers located outside the State of Missouri unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center;
- The services are approved in advance by Anthem.

Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center, or Ambulance services related to an Emergency for transportation to a Hospital.

Medical Services

Your Medical benefits do not cover:

Abortions. Abortions for pregnancies, other than those that place the woman in danger of death unless an abortion is performed.

Administrative Charges. Charges to complete claim forms, Charges to get medical records or reports, and Membership, administrative, or access fees charged by physicians or other Providers. Examples include, but are not limited to, fees for educational brochures or calling You to give You test results.

Affiliated Providers. Services 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 Allowed Amount for basic and primary services for 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, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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.

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

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. Upon 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 ventricular assist devices used as a bridge to transplantation, or as a permanent alternative to heart transplantation, or the total artificial heart if the request meets Anthem Medical Policy criteria.

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

Before Effective Date or After Termination Date. Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

Charges in Excess of the Maximum Allowed Amount. Charges in excess of Our Maximum Allowed Amounts.

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

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

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

Complications of Non-Covered Services. Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan with the exception of Emergency services. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

Complications Resulting from Experimental/Investigative or non Medically Necessary Services or Treatment. With the exception of Emergency services, complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service

and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

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. Provided in connection with cosmetic Services, with the exception of Emergency services. Cosmetic Services are primarily intended to preserve, change or improve Your appearance or are furnished for social reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded Plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

Counseling Services. 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.

Custodial Care. Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces unless specifically stated as a Covered Service.

Dental Implants. For Dental implants unless specifically stated as a Covered Service.

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

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions (unless listed as a Covered Service in this Contract).
- services to improve dental clinical outcomes.

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

- Transplant preparation.
- Initiation of an immunosuppressive.
- Direct treatment of acute traumatic injury, cancer, or cleft palate, cleft lip, ectodermal dysplasia, orthognathic surgery, treatment of non-dental lesions and incision and draining of infection of soft tissue.

Diagnostic Admissions. Inpatient room and board or any charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an Outpatient basis.

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

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

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

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.)

Durable Medical Equipment. Covered Services does not include durable medical equipment except as specifically stated in “Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies” under “What is Covered.” Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specifically stated under “What is Covered.”
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For services or supplies primarily for educational, vocational, or training purposes, except for rehabilitative services and as otherwise specified herein.

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.

Experimental/Investigative Services exclusions. Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

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

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

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

The information considered or evaluated by Us to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive.

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, State or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating physicians, other medical professionals, or Facilities or by other treating physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

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

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

Family/Self. 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, unless medically necessary, (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

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

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

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as set forth in this Certificate.

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

Gynecomastia. For surgical treatment of gynecomastia.

Hair loss or growth treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Health Club Memberships and Fitness Services. Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or Facilities used for physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Home Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider, except for hospice care (see the “Hospice Care” benefit under “What is Covered”).
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.
- Personal Comfort items.

Hospice (Care). We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed in the “Covered Services” section 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.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

Impotency. For 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.

In-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos. Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.

Infertility Testing and Treatment. This Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Intoxicated. For any loss sustained or contracted in consequence of a Member’s being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

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.

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

Medical Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Medicare Benefits. (1) for which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A and B, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

Missed/Cancelled Appointments. For missed or cancelled appointments.

Nicotine. For treatment of nicotine addiction, except as required under Preventive Care Services.

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 the “What is Covered” section. This includes, but is not limited to, suture removal in an Emergency Room.

Not Medically Necessary. Any services or supplies which are not Medically Necessary.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as provided in the “What is Covered” section or as required by law. This exclusion includes, but 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.

Off label use. Off label use, unless We must cover the use by law or if We approve it.

Orthodontic Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

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

Orthotic Devices, Shoes or Shoe Inserts. Benefits are not provided for orthotic devices, shoes or shoe inserts except as set forth in this certificate. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

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

- Replacement of lost or stolen items.

Outdoor Treatment Programs and/or Wilderness Programs.

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 the “What is Covered” section 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; except when required to treat congenital defects or birth abnormalities of a newborn child;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Physician Stand-by Charges. For stand-by charges of a physician.

Physician/Other Practitioners' Charges. Physician/Other Practitioners' Charges including:

- 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 provided in the “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.

Practice of Chiropractic. Practice of Chiropractic shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine. The practice of chiropractic is declared not to be the practice of medicine and operative surgery or osteopathy within the meaning of chapter 334 and not subject to the provisions of the chapter.

Private Duty Nursing. For Private Duty Nursing Services unless specified in the “What is Covered” section.

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

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

Reconstructive Services. Reconstructive services except as specifically stated in the “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, except as specified in the “What is Covered” section.

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

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

Reversal of Sterilization. For reversal of sterilization unless resulting from an illness or injury.

Riot, Nuclear Explosion. For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation or under the influence of any narcotic unless administered on the advice of a physician.

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

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

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in the “What is Covered” section or as required by law.

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

Telephone/Internet Consultations. 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 provided under “Online Visits” in the “What is Covered” section.

Temporomandibular or Craniomandibular Joint Disorder. Temporomandibular Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

Therapy – Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

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

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions. Non-Covered Services for transportation and lodging include, but are not limited to:

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

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

Vision Orthoptic Training. For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

Waived Copayment. Coinsurance, or Deductible. For any service for which You are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-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 Contract. 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 if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger (PBM).
- Clinically-Equivalent Alternatives Certain Prescription Drugs may not be covered if You could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at www.anthem.com. If You or Your Doctor believes You need to use a different Prescription Drug, please have Your Doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary
- Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
- Compound Drugs. Unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Compound Drug to be considered Medically Necessary, the physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Compound Drug is more medically beneficial than the clinically equivalent alternative.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider’s Office / Facility: Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the “Therapy services” section, or Drugs covered under the “Medical Supplies” benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter 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 which are over any quantity or age limits set by the Plan or 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.
- 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.
- Drugs not approved by the FDA.
- Off label use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onychomycosis Drugs. Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.

- Over-the-Counter Items may not be covered. 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 Prescription 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.
- Gene Therapy as well as any Drugs, procedures, health care services related to it that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, thus treating a disease or abnormal medical condition.
- Drugs prescribed by Providers lacking qualifications/certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications as determined by Anthem.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a Member of Your immediate family, including Your spouse, Domestic Partner, child/stepchild, brother/stepbrother, sister/stepparent, parent/stepparent, in-law, or self.
- Charges Not Supported by Medical Records Charges for services not described in Your medical records.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional or Dietary Supplements Nutritional and/or dietary supplements, except as described in this Contract or that We must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.

Pediatric Dental Care

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

- Dental Care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- Dental services or health care services not specifically covered under the Contract (including any Hospital charges, Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Contract).
- Services of anesthesiologist, unless required by law.
- Anesthesia Services, (such as intravenous conscious sedation and general anesthesia) are not covered when given separate from complex surgical services.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Contract.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Contract.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Contract.
- 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, unless the partial denture cannot satisfactorily restore the case.
- 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.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the effective date of this policy or received after the coverage under this Contract has ended.

- Dental services given by someone other than a licensed Provider (dentist or physician) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this Contract.
- Occlusal or athletic mouth guards.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.

Pediatric Vision Care

Your vision care services do not include 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 Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse or Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- 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, including Inpatient or Outpatient Hospital vision care, except as specified "What is Covered" section of this Contract.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Contract.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in this Contract.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of our Formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.

CLAIMS PAYMENTS

This section describes how Your claims are administered, explains the Cost-sharing features of Your Plan, and outlines other important provisions. The specific Cost-sharing features, and the applicable benefit percentages and/or limitations, are outlined in the “Schedule of Cost Shares and Benefits” section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Maximum Allowed Amount

General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by Network and Non-Network Providers is based on Your Plan’s Maximum Allowed Amount for the Covered Service that You receive. Please also see “Inter-Plan Programs” provision for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable prior-authorization, utilization management, or other requirements set forth in Your Plan .

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out of Network Provider under this Plan are not covered except for Emergency care, or when services have been previously authorized by Us. When You receive Covered Services from an Out of Network Provider either in an Emergency or when services have been previously authorized, 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.

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

Provider Network Status

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

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

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. If You use a Non-Network Provider, Your entire claim will be denied except for Emergency care, or unless the services were previously authorized by Us.

For Covered Services You receive in an Emergency or if previously authorized from a Non-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Us:

For Covered Services You receive in an Emergency or if previously authorized from an Out of Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Us:

1. An amount based on Our Non-Network 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 (1) 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 Non-Network Provider.

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

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

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

Member Services is also available to assist You in determining Your 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 Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

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 Coinsurance).

We will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Non-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your day/visit limits.

In some instances You may only be asked to pay the lower Network Cost-Sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider Facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or Facility, You will pay the Network Cost-Share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

We and/or Our designated Pharmacy Benefits Manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by Us. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copayment or Coinsurance.

The following are examples for illustrative purposes only; the amounts shown may be different than this Plan's Cost-Share amounts; see Your "Schedule of Cost Shares and Benefits" for Your applicable amounts.

Example: Your Plan has a Coinsurance Cost-Share of 20% for Network services after Deductible has been met.

You undergo a non-Emergency surgical procedure in a Network Hospital. The Hospital has contracted with a Non-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Non-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; Your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from Us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, Your total out-of-pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.
- You choose a Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket responsibility would be \$300.
- You choose a Non-Network surgeon. Unless previously authorized by Us, all services will be denied and You will be responsible for the total amount billed.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, We may authorize the Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency services from a Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Member Services for authorized services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Plan's Cost-Share amounts; see Your "Schedule of Cost Shares and Benefits" for Your applicable amounts.

Example:

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

Your Plan has a \$25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

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

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

Deductible Calculation

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

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

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

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

Out-of-Pocket Limit Calculation

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

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

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

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

The Non-Network Out-of-Pocket Limit does not include Coinsurance for any Non-Network Human Organ and Bone Marrow/Stem Cell/Cord Blood Transplant.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

When You receive care outside of the Anthem Service Area, You will receive it from one of two kinds of Providers. Most Providers (“participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Providers (“nonparticipating Providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of Providers. Anthem covers only limited healthcare services received outside of the Anthem Service Area. For example, Emergency Care or Urgent Care services received at an Urgent care Center obtained outside the Anthem Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard Program

If You receive Covered Services under a value-based program inside a Host Blue’s Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees

that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

In certain situations, We may use other pricing methods, such as billed charges the pricing We would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount We will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. Blue Cross Global Core Program

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care services outside of the United States. Remember to take an up to date health ID card with You.

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

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" section.

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

- Doctors services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

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

When You need Blue Cross Blue Shield Global Core claim forms You can get international claims forms in the following ways:

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

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

Claims Review for Fraud, Waste and Abuse

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, Urgent Care services received in an Urgent Care Center or other services authorized by Us in accordance with this Certificate from non-participating or Non-Network Providers could be balanced billed by the non-participating Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Payment Innovation Programs

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

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

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

Relationship of Parties (Anthem and Network Providers)

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

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

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or Us.

Authorized Services

In some circumstances, such as where there is no Network Provider or participating Provider available for the Covered Service, We may authorize the Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency services from a Non-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize a Network cost share amount to apply to a Covered Service received from a Non-Network/non-participating Provider, You may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

Payment of Benefits

You authorize Us to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Subscriber's Contract), or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable State law.

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

Services Performed During Same Session

We may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to Our Maximum Allowed Amount. If services are performed by Non-Network Providers, then You are responsible for any amounts charged in excess of Our Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact Us for more information.

Assignment

Members cannot legally transfer the coverage. Benefits available under this Contract are not assignable by any Member without obtaining written permission from the Plan, unless in a way described in this Contract.

If Prescription Drugs are provided by a licensed pharmacist, We will recognize a valid assignment by You to the pharmacist of Your right to receive payment for the Prescription Drugs subject to the following conditions:

The claim must provide all of the information specified above, and Our payments must not have been made to You prior to Our receipt of the assignment.

Notice of Claim and Proof of Loss

Written notice of a claim must be submitted to Us within 20 days of when the Covered Services were provided, or as soon thereafter as is reasonably possible. All claims must be submitted to Us within 15 months of when the Covered Services were provided, or as soon thereafter as is reasonably possible.

We will process the claim within 30 processing days of its receipt, unless information necessary to process the claim is not available. In that case, We will process the claim within an additional 10 processing days after receipt of the additional information.

Claims not processed by the 45th processing day of receipt require Us to pay the Provider or individual who filed the claim interest of 1% per month and a penalty in an amount equal to one percent of the claim per day until the claim is paid. The interest and penalty shall be calculated based upon the unpaid balance of the claim as of the 45th processing day,

All Benefits payable under this Contract will be paid no more than 30 days after receipt of due proof of loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one Year from the time proof is otherwise required.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Us, or contact Member Services and ask for a claim form to be sent to You. The form will be sent to You within 15 days. If You do not receive the claim form within that time, You will

be deemed to have complied with the Notice of Claim requirements upon submitting, within the time fixed in the "Notice of Claim" section (above) for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

We will respond to a filed claim within 10 days of its receipt by:

- sending an acknowledgement of the date We received Your claim; or
- sending notice of the status of the claim that includes a request for additional information.

These provisions do not apply if We pay the claim within 10 days after We receive it.

Claims submitted by a public (government operated) Hospital or clinic will be paid by Us directly, as long as You have not already received benefit under that claim. We will pay all claims within 30 days after We receive proof of loss. If You are dissatisfied with Our denial or amount of payment, You may request that We review the claim a second time, and You may submit any additional relevant information.

Member's Cooperation

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

You agree (on behalf of Yourself and as authorized representative of Your enrolled Dependents) to furnish all information required by Us, Our affiliates, agents or designees, and that any Provider, insurance or reinsurance company, health services corporation, health maintenance organization, medical information bureau, Medicare fiscal agent, employer or third party administrator, is authorized and directed to release any and all information relating to history, diagnosis, prognosis, treatment and Covered Services relating to any condition (including but not limited to alcohol/Substance Abuse and HIV) to Us, Our affiliates, agents or designees, who are also authorized to receive and release such information in connection with: investigating, evaluating and/or processing claims; utilization, credentialing, quality or medical management programs; managing the provision of services; insurance; and carrying out any other lawful purpose relating to coverage.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for benefits.

Overpayment of Claims

If We make any payment to a Provider, to You, or to any other organization that is wholly or partially incorrect under the terms of this Contract, We will seek reimbursement from You, the Provider or other organization to which payment was made. We will not request a refund or offset against a claim more than 12 months after paying the claim, except in cases of fraud or misrepresentation by the Provider. This will apply regardless of the reason for the overpayment. This provision will survive the termination of this Contract.

Explanation of Benefits (EOB)

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

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

IF YOU ARE COVERED BY MORE THAN ONE POLICY

Variable Deductible (Coordination of Benefits)

When a Member has other valid coverage, the applicable Deductible amount will be determined as follows:

Other valid coverage means: any group or individual Hospital, surgical or medical insurance policy or medical practice or other prepayment Plan or any other Plan or program, whether insured or uninsured, or by reason of State or federal law, including automobile medical payment coverage.

The amount paid under other valid coverage for services received by a Member will be compared to the individual Deductible applicable to this Contract. If the amount paid by the other valid coverage is less than the individual Deductible under this Contract, We will calculate the Member's benefit as if there were no other valid coverage. If the amount paid by the other valid coverage is greater than the Deductible under this Contract, the amount paid by other valid coverage will replace and satisfy the individual Deductible under this Contract. We will then process the remaining amount of covered expenses, as specified by the other valid coverage, under the provisions of this Contract.

If more than one policy containing a variable Deductible provision provides benefits for medical expenses incurred by a Member, the amount of benefits payable by each company will be determined as follows:

- After applying benefits payable under any Plan(s) not containing variable Deductibles, each variable Deductible Plan shall share remaining expenses on a pro rata basis; and
- Each Plan's pro rata share of expenses will be that portion of the total remaining expenses as each Plan's benefits bears to the total benefits payable under all variable Deductible Plans.

Coordination with Medicare

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

Except when federal law requires the Plan to be the primary payor, the benefits under This Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purpose of the calculation of benefits, if the Member has not enrolled in the Medicare Part B, We will calculate benefits as if they had enrolled.

IF YOU HAVE A COMPLAINT OR AN APPEAL

If You have a complaint, please call 1-800-392-1104. A Client Services representative will review Your records and investigate Your complaint.

If You are not satisfied with the review and Our response, You, Your health care Provider or Your authorized representative acting upon Your behalf, may file a Grievance. You also may file a Grievance without first requesting a review. A Grievance is a written complaint submitted by or on behalf of a Member regarding the a) availability, delivery or quality of health Care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review; b) claims payment, handling or reimbursement for health Care services; or c) matters pertaining to the contractual relationship between a Member and the Company. We will not charge You anything to file a Grievance.

Under Missouri law, an Adverse Determination is a denial, reduction or termination of benefits because the care does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness.

How To File An Expedited Grievance Review

If Your complaint concerns a decision or action by Us that could significantly increase the risk to Your life, health, or ability to regain maximum function, the Grievance may be made by phone, or fax instead of going through the mail. Please call 1-800-992-5498, or fax Your request to 314-923-8542. This is an expedited Grievance. We will notify the person filing the Grievance within 24 hours of all information We need to evaluate the Grievance.

Then, We will make a decision within 24 hours after We receive the information and notify You orally of the determination within 72 hours after receipt of the expedited review request. We will send written confirmation to You within three working days.

How To File a First Level Grievance for Review

A standard Grievance should be submitted to Us in writing and sent to the address listed below:

Anthem Blue Cross Blue Shield
Grievances and Appeals
PO Box 105568
Atlanta GA 30348-5568

Dental Coverage Appeals

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

Anthem Blue Cross and Blue Shield
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View 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

If You send Us a written complaint, please include with Your letter any records or other information You believe supports Your Grievance. We will carefully consider Your complaint. We will not charge You anything to file a Grievance, and filing a Grievance will not affect Your benefits.

We will acknowledge in writing receipt of the Grievance within 10 working days, unless it is resolved within that period of time.

Then, We will conduct a complete investigation of the Grievance within 20 working days after receipt of it, unless the investigation cannot be completed within this time. If the investigation cannot be completed within 20 working days after receipt of the Grievance, You will be notified in writing on or before the 20th working day, and the investigation will be completed within 30 additional days. The notice will include specific reasons why additional time is needed for the investigation.

A person or committee who was not involved in the initial decision and does not report to, or is not subordinate to, the person involved in the initial decision, will review Your complaint. If the decision You are asking Us to review was based on a medical judgment, the review will include consultation with a health care professional who has training and experience in the appropriate medical field and who was not involved in the initial decision. The person or committee who reviews Your Grievance will not be bound by, or be expected to defer to, the initial decision.

Within five working days after the investigation is completed, the representative not involved in the circumstances giving rise to Your Grievance or its investigation will decide upon the appropriate resolution and notify You in writing of Our decision and Your right to file a Grievance for a second review. The notice will explain the resolution of the Grievance and the right to file a Grievance in terms that are clear and specific. You, or the person who filed the Grievance upon Your behalf, will be notified of the resolution within 15 working days.

If We deny Your Grievance, You may voluntarily request a second Grievance by writing to the address above. If You do file a voluntary second Grievance, We agree that any applicable statute of limitation will be temporarily suspended while the second Grievance is pending.

How to File a Second Level Grievance for Review

If You remain dissatisfied with the response to the first level review, You may submit any additional information, including written comments, records or documents that You want Us to consider along with Your Grievance letter, addressed to Us at the address below.

Anthem Blue Cross Blue Shield
Grievances and Appeals
PO Box 105568
Atlanta GA 30348-5568

For Appeals or reviews related to Your dental benefits:
Anthem
Attention: Appeals Unit
P.O. Box 1122
Minneapolis, MN 55440-1122

Please submit Appeals regarding Your vision coverage to the following address:
Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

The Grievance will be reviewed by the grievance advisory panel within 20 working days after receipt, unless the investigation cannot be completed within this time. A grievance advisory panel consists of other enrollees; Our representatives who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and, where the grievance involves an adverse determination, a majority of persons that are appropriate clinical peers in the same or similar specialty as would typically manage the case being reviewed who were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance. If the investigation cannot be completed within 20 working days after receipt of a Grievance, You, or Your representative acting upon Your behalf, will be notified in writing on or before the 20th working day, and the investigation will be completed within 30 days thereafter. The notice will State specific reasons why additional time is needed for the investigation. A panel of individuals who were not involved in either the initial decision or the first Grievance will review Your second Grievance. If the

decision You are asking Us to review is based on a medical judgment, the committee will include, or will consult with, two or more health care professionals of the same or a similar specialty that would typically manage the medical condition or treatment plan under review.

Within five working days after the investigation is completed, the grievance advisory panel will decide upon the appropriate resolution of the Grievance, and We will notify You in writing, in terms that are clear and specific, of the panel's decision. We will also notify You of Your right to file an Appeal with the director of the Missouri Department of Insurance. The notice will contain the toll-free telephone number and address of the director. You, or the person You authorized to represent You in filing the Grievance, will be notified of the resolution of the Grievance within 15 working days after the investigation is completed. Your decision to file an Appeal will not affect Your rights to any other benefits under Your coverage. Your relative, friend, lawyer or other representative may help You with Your Appeal.

At any time, You can request free copies of all records and other information We have relevant to Your written complaint, including the name of any health care professional We consulted. To obtain copies, send a written request to the Grievance Unit address given above.

Review of Your Complaint By the MDI

At any time, You may request help from, or file a Grievance with, the Missouri Department of Insurance (MDI). The number is 1-800-726-7390. The address is:

Missouri Department of Insurance
Consumer Complaints
P.O. Box 690
Jefferson City, MO 65102-0690

If You file a Grievance with the MDI and Your Grievance is not yet resolved after the MDI completes its consumer complaint process, the MDI will refer Your Grievance to an independent review organization (IRO). Within twenty calendar days after receiving Your Grievance, the IRO will complete an external review and will submit its opinion to the MDI. Within twenty-five calendar days of receiving the IRO's opinion, the MDI will notify You of its decision, and it will be binding on You and Us. You may request an expedited external review if Your Grievance involves Emergency care (and You have not yet been discharged from the Hospital) or if a delay would jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You request an expedited review, the IRO will submit its opinion to the MDI as expeditiously as possible; and the MDI will notify You of its decision as expeditiously as possible, but no more than seventy-two (72) hours after the IRO receives the request for an expedited review.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than ten Years after the date the claim is required to be furnished to Us.

Prescription Drugs

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

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

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

Subscriber Eligibility

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

1. Be determined by the Marketplace to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Marketplace 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 Missouri and meet the following applicable residency standards:

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

- Not be living in an institution (reference to “institution” does not include a penal institution);
- Be capable of indicating intent;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Marketplace.

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

- Not be living in an institution (reference to “institution” does not include a penal 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 Marketplace.

6. Agree to pay for the cost of Premium that Anthem requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be entitled to or enrolled in Medicare Parts A/B;
9. 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. is seeking employment (whether or not currently employed); or
3. 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 Marketplace Service Areas:

1. If all of the Members of a tax household are not living within the same Marketplace service area, any Member of the tax household may enroll in a Qualified Health Plan through any of the Marketplaces 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 Marketplace, a tax Dependent may only enroll in a Qualified Health Plan through that Marketplace, or through the Marketplace that services the area in which the Dependent meets a residency standard.

Dependent Eligibility

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 Marketplace to be a Qualified Individual, meet all Dependent eligibility criteria established by the Marketplace and be:

1. The Subscriber's legal spouse.
2. The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under State law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
 - a. For purposes of this Contract, 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 Marketplace. The Marketplace 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.
 - a. This does include children not claimed as a Dependent on the parent's federal income tax return.

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 Marketplace must certify the Dependent's eligibility. The Marketplace 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 Marketplace if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Marketplace may require the Subscriber to submit proof of continued eligibility for any Dependent. Your failure to provide this information could result in termination of a Dependent's coverage. Proof may be required at reasonable intervals during the first two Years after the Dependent reaches the Dependent age limit, and no more frequently than once each Year thereafter.

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

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

Open Enrollment

As established by the rules of the Marketplace, 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 Marketplace.

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

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Marketplace or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Marketplace. In such cases, the Marketplace may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Marketplace 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 Marketplace 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; provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move;
- A Qualified Individual's or enrollee's QHP is decertified; and
- A Qualified Individual or enrollee demonstrates to the Marketplace, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Marketplace may provide.

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

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. To continue coverage beyond the first 31 days, please contact the Marketplace within 60 days of the date of birth to add the child to the Subscriber's Contract and You must pay Anthem timely for any additional Premium due.

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.

Please contact the Marketplace within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Contract and You must pay Anthem timely for any additional Premium due.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Contract must be submitted to the Marketplace

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.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable State or federal law, to enroll Your child under this Contract, and the child is otherwise eligible for the coverage, You must request permission from the Marketplace for Your child to enroll under this Contract and once approved by the Marketplace, We will provide the benefits of this Contract 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 Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Marketplace based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid 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 unless the Subscriber timely requests a different Effective Date. 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;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event; and
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event.

Effective dates for special enrollment due to loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment;
6. Individual who no longer resides, lives or works in the Anthem Service Area, except does not apply to a child who does not reside with the parent or in Our Service Area;
7. A situation in which a Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA benefits.

Effective dates for special enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

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

Notice of Changes

The Subscriber is responsible to notify the Marketplace of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Marketplace must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Marketplace 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 Marketplace 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 Marketplace. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Marketplace 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 and understand that all rights to benefits under this Contract are subject to the condition that all such information is accurate. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed. Termination shall be without prejudice to any claim originating prior to the Effective Date of termination.

Termination of the Member

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

1. The Member terminates his or her coverage with appropriate notice to the Marketplace.
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Marketplace (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the Service Area, etc.). In this case, the Marketplace will send a notice to the Member. Coverage through the Marketplace ends on the last day of the month following the month in which the Marketplace notifies the Member (unless the Member requests an earlier termination date). Provided the Member continues to reside within the Service Area, the Member may continue coverage with Us under another Contract for the same product. Please refer to "Changes Affecting Eligibility and Special Enrollment" in the Eligibility and Enrollment section;
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. In such an event, the Member may enroll in another QHP or coverage for the same product outside the Marketplace that is offered by the Plan on a guaranteed issue basis; or
6. The Member changes to another QHP.

Advance Payments of the Premium Tax Credit (APTC) and Termination

Decertification of a QHP or termination of a QHP due to a move of residence outside of the Service Area or loss of eligibility does not mean that a Member receiving APTC is no longer eligible to receive such assistance. Members should contact the Marketplace to confirm the status of any APTC.

"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 applicable 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, Children's Health Insurance Program (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 Marketplace (examples: divorce, dissolution of domestic partnership, coverage 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 Marketplace, unless the Member requests an earlier termination Effective Date.
4. In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, 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 Contract, shall become the Subscriber.

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

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal laws and regulations. The Member may renew this Contract 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 continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract.
3. This Contract has not been terminated.

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 Marketplace or the QHP Issuer 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. If a Member loses eligibility for coverage through the Marketplace, the Member may be eligible to renew coverage outside the Marketplace. Please contact the Plan for more information.

Rescission

If within two (2) Years after the Effective Date of this Contract, 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 Contract 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 Dependent 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 Contract.

This Contract 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 Contract. Termination will be

effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) Years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud. After this policy has been in force for a period of two Years during the lifetime of the Member, it shall become uncontestable as to the statements contained in the application.

Discontinuation of Coverage

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

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain 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 Contract 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 Calendar Year We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to terminate the Contract as provided herein. You will be liable to Us for the Premium 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 Contract 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 Contract will stay in force and claims will be pended unless prior to the date Premium is due You give timely written notice to Us that the Contract is to be terminated. If You do not make the full Premium payment during the grace period, the Contract will be terminated on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last day through which Premium is paid.

After Termination

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

Removal of Members

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

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

Reinstatement

If Your Contract has been terminated for non-payment, We may decline to reinstate Your coverage, or We may reinstate Your coverage by accepting the Premium due. However, We have the right to require an application for Reinstatement and issue a conditional receipt for the Premium. If You have not been notified in writing, within 45 days of the date of the conditional receipt, of Our disapproval of Your application for Reinstatement; Your Contract will be reinstated on the 45th day following the date of the conditional receipt.

Premium accepted in connection with a Reinstatement will not be applied to a period more than 60 days prior to the date of Reinstatement.

If We fail to provide You with a 30 day written notice of Our termination, coverage will remain in effect at the existing Premium until 30 days after the notice is given or the Effective Date of replacement coverage obtained by the subscriber, whichever occurs first.

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Premiums Paid by a Third Party

Anthem Blue Cross will accept Premium payments made on behalf of Subscribers if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and cost-sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, Anthem does not accept Premium payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan.

Medical Policy and Technology Assessment

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

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

Care Coordination

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

Value-Added 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 Contract 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.

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 any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.)

Entire Contract

Note: The laws of the State of Missouri will apply unless otherwise stated herein.

This Contract, the application, and any Riders, Endorsements or attachments, if any, constitute the entire Contract between the Plan and the Subscriber and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Subscriber and any and all statements made to the Subscriber by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract. No change in this Contract shall be valid unless approved by one of Our executive officers and attached to this Contract. No agent has authority to change this Contract or to waive any of its provisions.

Program Incentives

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

Physical Examination

When a claim is pending, We reserve the right to request a Member to be examined by an applicable Provider, at Our expense. This will be requested as often as reasonably required.

Form or Content of Contract

No agent or employee of the Plan is authorized to change the form or content of this Contract. Changes can only be made through a written authorization, signed by an officer of the Plan.

Premium

Your Contract will renew each month if You pay Your Premium before the end of the grace period. The amount of Premium is printed on Your Premium notice; however, this amount is subject to change. We will not increase Premium for any reason without giving You at least 30 days written notice. We will then send You a new notice with the new Premium amount. The Premium for this Contract may change subject to, and as permitted by, applicable law.

Additionally, Your Premium may change on Your Contract anniversary date based on Your attained age.

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

If a Premium increase is necessary, We will bill You for the extra amount due. If this amount is not paid, this Contract will be terminated at the end of the grace period, and You will receive a refund of any unearned Premium.

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

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

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

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

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that he/she, in consultation with his/her Providers, is responsible for determining the treatment appropriate for his/her care. You may, for personal reasons, refuse to accept procedures or treatment recommended by Your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to You, and We shall have no obligation to have Network Providers available who will render the care.

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

Worker's Compensation

The benefits under this Contract are not designed to duplicate benefits that Members are eligible for under the Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under this Contract does not replace or affect any Worker's Compensation coverage requirements.

Other Government Programs

The benefits under this Contract shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payer. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Subrogation

Subrogation will not be allowed in any Plan as distinguished from the right of recovery.

Important Note

The Subscriber hereby expressly acknowledges his or her understanding that this Contract constitutes a Contract solely between the Subscriber and Healthy Alliance Life Insurance Company, dba Anthem Blue Cross and Blue Shield (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in a portion of the State of Missouri, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem, and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Subscriber for any of Anthem's obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of this Contract. This rule applies to any clerical error, regardless of whether it was the fault of the Subscriber or the Plan.

Policies and Procedures

The Plan is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Contract more orderly and efficient.

Waiver

No agent or other person, except an authorized officer of the Plan, is able to disregard any conditions or restrictions contained in this Contract, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information, unless written herein.

Additional Benefits

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

Right of Recovery and Adjustment

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

We have oversight responsibility of compliance with Provider and vendor Contracts. We may enter into a settlement or compromise regarding enforcement of these Contracts and may retain any recoveries made

from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

Notice

Any notice given under this Contract shall be in writing. The notices shall be sent to: Anthem Blue Cross & Blue Shield, P.O. Box 36550, Louisville, KY 40233. If We are forwarding You a notice, it will be sent to Your most recent address as it appears in the Plan's system records.

MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

You have the responsibility to:

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

If You would like more information, have comments, or would like to contact Us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on Your ID card.

We want to provide high quality benefits and customer service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your Contract or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the contract so they are easy to identify.

Advanced Payments of The Premium Tax Credit (APTC)

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 Facility

A residential or nonresidential Facility certified by the Department of Mental Health for treatment of alcoholism.

American Indian

An individual who is a member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Anthem Blue Cross and Blue Shield (Anthem)

The company providing the coverage under this Contract. The terms We, Us and Our in this Certificate refer to Anthem and its designated affiliates.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the "If You Have a Complaint or an Appeal" section of this Contract.

Authorized Services

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. For more information, see the "Claims Payments" section.

Benefit Period/Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan, as listed in the "Schedule of Cost-Shares and Benefits." If Your coverage ends earlier, the Benefit Period/Year ends at the same time.

Biosimilar/Biosimilars

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

Brand Drug

Prescription Drugs that we classify as Brand Drugs or our Pharmacy Benefits Manager (PBM) has classified as Brand Drugs through use of an independent proprietary industry database.

Calendar Year

A period beginning on January 1 and ending on December 31 of the same Year.

Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

Community Mental Health Center

A legal entity certified by the Department of Mental Health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals.

Contract

The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Controlled Substances

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

Copayment

A fixed amount you pay for a Covered Service, usually when you receive the service. The amount can vary by the type of Covered Service. The Copayment does not apply to the Deductible.

Cost-Share (Cost Sharing)

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

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section;
- Within the scope of the Provider's license;
- Rendered while coverage under this Contract is in force;
- Not Experimental or Investigational or not covered by this Contract; and

Authorized in advance by Us if such preauthorization is required in Contract.

Deductible

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Cost Shares and Benefits".

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 "Pediatric Dental Care".

Dependent

A member of the Subscriber's family who meets the rules listed in the "When Membership Changes (Eligibility)" section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with Us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Eating Disorder

Pica, Rumination Disorder, Avoidant/Restrictive Food Intake Disorder, Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, Other Specified Feeding or Eating Disorder, and any other Eating Disorder contained in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association where diagnosed by a licensed physician, psychiatrist, Psychologist, clinical Social Worker, licensed marital and family therapist, or professional

counselor duly licensed in the State where he or she practices and acting within their applicable scope of practice in the State where he or she practices.

Effective Date

The date that a Member's coverage begins under this Contract.

Emergency Medical Condition (Emergency)

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

- placing the health of the individual or another person in significant jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- Inadequately controlled pain; or
- With respect to a pregnant woman having contractions:
 - That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
 - That transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services (Emergency Care)

A health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider.

The term "**stabilize**" means, with respect to an Emergency Medical Condition:

To provide such medical treatment that no material deterioration of the condition is likely to result or occur before an individual may be transferred.

Exchange

A governmental agency or non-profit entity that makes Qualified Health Plans such as this plan available to Qualified Individuals.

Experimental/Investigative

A Drug, device, medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration (FDA) at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing Phase I, II, III or IV clinical trial or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating Facility or other Facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating Facility or other Facilities studying substantially the same Drug, device or medical treatment or procedure.

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

Facility

A Facility including but not limited to, a Hospital, freestanding ambulatory surgical Facility, chemical dependency treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Contract. The Facility must be licensed, accredited,

registered and approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.

Formulary

Listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Generic Drugs

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

Habilitative Services

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

Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Pharmacy Drugs) through a mail order service.

Home Health Care Agency

A Facility, licensed in the state in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member's home; and
- Is responsible for supervising the delivery of such services under a Plan prescribed and approved in writing by the attending physician.

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more doctors on hand at all times;
3. 24 hour nursing service; and
4. All the Facilities on site are needed to diagnose, care, and treat an illness or injury.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card/ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In-Network Pharmacy

A Network Pharmacy is a Pharmacy that has a 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 a Network Pharmacy near You, call Member Services at 1-800-700-2533/the telephone number on the back of your Identification Card.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility-where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Intensive Outpatient Program

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product

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

Maintenance Medication

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

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication.

Marketplace

A governmental agency or non-profit entity that makes Qualified Health Plans such as this plan available to Qualified Individuals.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the Claims Payments Section.

Medicaid

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

Medically Necessary Or Medical Necessity

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medically Necessary services must be cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) performed in the least costly setting that is medically appropriate.

Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

Mental Health And Substance Abuse

Mental Health means a condition classified as a mental disorder in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders. Substance Abuse means the psychological or physiological dependence upon or abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and the impairment of social or occupational role functioning or both.

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.

Network Provider

A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to You for the Network associated with this Contract.

Non-Network Provider

A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the Network associated with this Contract. Providers who have not contracted or affiliated with Our designated subcontractor(s) for the services they perform under this Contract are also considered Non-Network Providers.

Non-Network Pharmacy

A Pharmacy that does not have a Network Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered.

Out-Of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does not include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract. Please see the 'Schedule of Cost Shares and Benefits' for details

Outpatient

A Member who receives services or supplies when not an Inpatient.

Partial Hospitalization Program

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

A place licensed by State law where you can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your doctor.

Pharmacy And Therapeutics (P&T) Process

Process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company with which Anthem contracts to manage Pharmacy benefits. Anthem's PBM has a nationwide network of Retail Pharmacies, a mail service Pharmacy, and clinical services that include Formulary management.

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

Plan

The set of benefits, conditions, exclusions and limitations described in this document.

Practice of Chiropractic

The science and art of examination, diagnosis, adjustment, manipulation and treatment both in inpatient and outpatient settings, by those methods commonly taught in any chiropractic college or chiropractic program in a university which has been accredited by the Council on Chiropractic Education, its successor entity or approved by the board.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Predetermination

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay Anthem to establish and maintain coverage under this Agreement.

Prescription Drug (Drug)

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 Order

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

Primary Care Physician ("PCP")

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by Us. A

PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

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

Psychologist

A licensed clinical Psychologist. In States where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Qualified Health Plan or QHP

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 (QHP Issuer)

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Rehabilitative Services

Health care services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or outpatient settings.

Residential Treatment Center/Facility

A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more Doctors available at all times.
3. Residential treatment takes place in a structured Facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Pharmacy

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

Self-Administered Drugs

Drugs that are administered which do not require a medical professional to administer.

Service Area

The geographical area, designated by Us, in which the program described in this Contract is marketed and sold. See list of counties in Our Service Area: Adair, Audrain, Barton, Bollinger, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Gasconade, Hickory, Howard, Howell, Iron, Knox, Laclede, Lewis, Linn, Macon, Madison, Maries, Marion, McDonald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Oregon, Osage, Ozark, Pemiscot, Perry, Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, Stoddard, Stone, Sullivan, Taney, Texas, Wayne, Webster, Wright. The Service Area is subject to change without notice. Please call the number on the back of your ID card to confirm the most current Service Area.

Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Social Worker

A licensed Clinical Social Worker. In States where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

Specialty Care Physician (Specialist or SCP)

A physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician Specialist is a doctor who has added training in a specific area of health care.

Specialty Drugs

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 or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

Each of the 50 States and the District of Columbia.

Subscriber

The Member who applied for coverage and in whose name this Contract is issued.

Tax Dependent

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

Tax Filer

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

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

Total Disability (Or Totally Disabled)

A subscriber or a Dependent who had been actively working is considered Totally Disabled if the Member is unable to perform the material and substantial duties of his or her occupation for a period of at least 12 months.

A retiree or a Dependent who had not been actively working is considered Totally Disabled if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. (in any of these situations, the disability may be either permanent or temporary.)

Urgent Care

Medical care for an unexpected illness or injury that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room.

Urgent Care Center

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

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

We, Us and Our

Healthy Alliance Life Insurance Company Anthem Blue Cross and Blue Shield.

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

M bédé dyí-bèdèin-dèè b'é m k'é b'í n'ia k'e k'e gbo-kpá- kpá dyé d'é m bídí-wùdùün b'ó pídyi. Dá mébà jè gbo-gmò Kpòè n'èbà n'ia n'ì Dyí-dyoìn-b'èè k'è b'é m k'é gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরামিতি নম্বরকে কল করুন। (TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin n̄ yic ba ye l̄k n̄ yök ku b̄e yi kuny n̄ thōn̄ yin j̄am ke cin w̄eu tōu k̄e piiny. Cl r̄an tōn̄ d̄e ke k̄e lui n̄ n̄amba d̄en t̄ n̄e I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας ὄωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nomba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិជំរុញការទទួលបានព័ត៌មាននេះ និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅលេខសេវាសមាជិកដ៏មានលើកលែង ID របស់អ្នកដើម្បីទទួលបានជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo

Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodiílnih. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodiílnih. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੇਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian

Avei dreptul să obinei aceste informaii i asistenă în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totoi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD: 711)۔

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און היילפט אין אייער שפראך בחינם. באדינונגען נומער אויף אייער קארטל פאר היילף (TTY/TDD: 711)

Yoruba

O ní ètò láti gba ìwífún yìí kí o sì èrànwọ ní èdè rẹ lófè. Pe Nọmbà àwọn ipèsè ọmọ-ẹgbé lóri kààdì ìdánimọ rẹ fún ìrànwọ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.