Certificate of Coverage

(Referred to as “Booklet” in the following pages)

Anthem Silver Pathway CT PPO 4500/0%/7900

Anthem Health Plans, Inc.,
d/b/a Anthem Blue Cross Blue Shield

(Referred to as “Anthem” in the following pages)

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 Member Services at the number on the back of your Identification Card.

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, following a pre-approved treatment plan, or procedures for obtaining Authorized Services. 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.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayments, Coinsurance, and out-of-pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayments, Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption, or as noted in "Eligibility and Enrollment – Adding Members".

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans other than Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a

written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet 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 Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

Your Group has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. The Group Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., Group, 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 Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem. 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 Services 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!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our 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. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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.

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What You Pay for Covered Services

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Anthem
Small Group Market
Anthem Silver Pathway CT PPO 4500/0%/7900

Schedule of Benefits

Your Plan provides you with the option to lower your out-of-pocket costs for certain services by going to Site-of-Service Providers, Freestanding Providers, or Surgical Centers. These Providers may have lower cost-shares and Maximum Allowed Amounts, reducing your Out-of-Pocket costs for certain services. When you use the "Find a Doctor" tool on anthem.com look for the "SOS" indicator under the Provider's name, and when applicable, the tool will automatically sort by Benefit Tier and show these providers first in your results.

In the following "Schedule of Benefits", Site-of-Service or Freestanding Providers, and Surgical Centers will be shown in the first Cost-Sharing column, otherwise "Not Applicable" will appear and benefits will be available at the In-Network Participating Providers level.

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Plan Deductible			
Individual	$4,500 per Member		$13,500 per Member
Family	$9,000 per Family		$27,000 per Family
Out-of-Pocket Limit			
Individual	$7,900 per Member		$23,700 per Member
Family	$15,800 per Family		$47,400 per Family
Includes Deductibles, Copayments and Coinsurance			
Provider Office Visits			
Adult / Pediatric Preventive Visit	Not Applicable	No Cost-Share	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Primary Care Provider Office Visits Includes services for illness, injury, follow-up care, and consultations	Not Applicable	$30 Copayment per visit	30% Coinsurance after Deductible is met
Specialist Office Visits	Not Applicable	$45 Copayment per visit after Deductible is met	30% Coinsurance after Deductible is met
Mental Health and Substance Abuse Office Visit	Not Applicable	$30 Copayment per visit	30% Coinsurance after Deductible is met
Outpatient Diagnostic Services			
Advanced Radiology CT/PET Scan, MRI	$75 Copayment per service up to an annual maximum of $375 for MRI, MRA, CAT, CTA, PET and SPECT scans **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Laboratory Services	No Cost-Share **at an Independent Lab, Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Non-Advanced Radiology X-ray, Diagnostic	No Cost-Share **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Mammography Ultrasound	No Cost-Share **at Site-of-Service or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Prescription Drugs – Retail Pharmacy 30-day supply per Prescription Order at a Retail Pharmacy. Up to a 90-day supply is available at Maintenance Pharmacies for Tiers 1, 2, and 3. When you get a 90-day supply at Maintenance Pharmacy, three (3) Retail Pharmacy Copayments or Coinsurance maximums (one for each 30-day period) will apply. **Copayment and Coinsurance maximum amounts shown below are based on a 30-day supply per Prescription Order**.			
Tier 1 - Typically Generic Prescription Drugs	Not Applicable	$5 Copayment per Prescription Order	50% Coinsurance
Tier 2 – Typically Preferred Brand Prescription Drugs	Not Applicable	$50 Copayment per Prescription Order	50% Coinsurance
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	Not Applicable	30% Coinsurance to a Coinsurance maximum of $500 per Prescription Order after Deductible is met	50% Coinsurance after Deductible is met
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order after Deductible is met	50% Coinsurance after Deductible is met
Prescription Drugs – Mail Order Pharmacy 90-day supply per Prescription Order for Tiers 1, 2, and 3, and a 30-day supply per Prescription Order for Tier 4.			
Tier 1 - Typically Generic Prescription Drugs	Not Applicable	$13 Copayment per Prescription Order	Not Covered
Tier 2 – Typically Preferred Brand Prescription Drugs	Not Applicable	$150 Copayment per Prescription Order	Not Covered
Tier 3 – Typically Non-Preferred Brand Prescription Drugs	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,500 per Prescription Order after Deductible is met	Not Covered

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Tier 4 – Typically Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 30-day supply.	Not Applicable	30% Coinsurance to a Coinsurance maximum of $1,000 per Prescription Order after Deductible is met	Not Covered
Outpatient Rehabilitative and Habilitative Therapy Services Up to 40 visits for Rehabilitative services and up to 40 visits for Habilitative services per calendar year. Limits are combined for physical, speech, and occupational therapy.			
Speech Therapy	Not Applicable	$30 Copayment per visit after Deductible is met **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Physical and Occupational Therapy	Not Applicable	$30 Copayment per visit after Deductible is met **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Other Services			
Chiropractic Care Up to 20 visits per calendar year.	Not Applicable	$45 Copayment per visit after Deductible is met **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Diabetic Equipment and Supplies	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Durable Medical Equipment (DME)	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Home Health Care Services Up to 100 visits per calendar year provided by a Home Health Care Agency.	Not Applicable	No Cost-Share after $50 Deductible is met	25% Coinsurance after $50 Deductible is met
Outpatient Services In a hospital or ambulatory facility	$300 Copayment per visit **at Surgical Centers or Freestanding Providers**	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Inpatient Hospital Services Including mental health, substance abuse, maternity, hospice, and skilled nursing services Please also see "Other Services Continued" section.	Not Applicable	$500 Copayment per day up to $2,000 per admission after Deductible is met **at an acute general Hospital**	30% Coinsurance after Deductible is met
Emergency and Urgent Care			
Ambulance Services	No Cost-Share after Deductible is met	No Cost-Share after Deductible is met	No Cost-Share after In-Network Deductible is met
Emergency Room	20% Coinsurance after Deductible is met	20% Coinsurance after Deductible is met	20% Coinsurance after In-Network Deductible is met
Urgent Care Services	Not Applicable	$30 Copayment per visit **at a Walk-In Center** $75 Copayment per visit after Deductible is met **at an Urgent Care Facility (Urgent Care Center)**	30% Coinsurance after Deductible is met
Pediatric Dental Care (For children under age 19)			
Diagnostic & Preventive	Not Applicable	No Cost-Share	No Cost-Share
Basic Services	Not Applicable	40% Coinsurance after Deductible is met	40% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Major Services	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Orthodontia Services Medically necessary only	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Pediatric Vision Care (For children under age 19)			
Prescription Eye Glasses One pair of frames and lenses or contact lens per calendar year	Not Applicable	**Lenses:** No Cost-Share after Deductible is met **Collection frame:** No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
Routine Eye Exam by a Specialist One exam per calendar year	Not Applicable	$45 Copayment per visit after Deductible is met	30% Coinsurance after Deductible is met
Adult Vision Care (For Members age 19 and Older)			
Prescription Eye Glasses One pair of frames and lenses every other calendar year	Not Applicable	**Lenses:** $20 Copayment after Deductible is met **Frame:** Covered up to $130 after Deductible is met	After Deductible is met: **Single Vision Lenses:** Reimbursed up to $25 **Bifocal Lenses:** Reimbursed up to $40 **Trifocal Lenses:** Reimbursed up to $55 **Frames:** Reimbursed up to $45
Contact Lenses One set of contact lenses every other calendar year. Available only if the eyeglass lenses benefit is not used.	Not Applicable	**Elective Contact Lenses:** Covered up to $80 after Deductible is met **Non-Elective Contact Lenses:** No Cost-Share after Deductible is met	After Deductible is met: **Elective Contact Lenses:** Reimbursed up to $60 **Non-Elective Contact Lenses:** Reimbursed up to $210

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Routine Eye Exam by a Specialist One exam per calendar year	Not Applicable	$45 Copayment per visit after Deductible is met	Reimbursed up to $30 after Deductible is met
Other Services Continued			
Allergy Office Visits and Allergy Testing	Not Applicable	$45 Copayment per visit after Deductible is met	30% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments	Not Applicable	$45 Copayment per visit after Deductible is met	30% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	Not Applicable	No Cost-Share after Deductible is met	50% Coinsurance after Deductible is met
Cardiac Rehab Therapy	Not Applicable	$45 Copayment per visit after Deductible is met **in an Office** No Cost-Share after Deductible is met **at an Outpatient Hospital Facility**	30% Coinsurance after Deductible is met
Home Dialysis and Infusion Therapy	Not Applicable	No Cost-Share after Deductible is met	30% Coinsurance after Deductible is met
Inpatient Rehabilitation Facility Up to 90 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	$500 Copayment per day up to $2,000 per admission after Deductible is met	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Online Visits When you visit www.LiveHealthOnline.com Telehealth is available at your PCP or Specialist Cost-shares listed in the Provider Office Visits section of this Schedule.	No Cost-Share for the first 12 visits, then a $15 Copayment applies **for Online visits other than Mental Health & Substance Abuse** $30 Copayment per visit **for Online Mental Health & Substance Abuse**	Not Applicable	Not Applicable
Partial Hospitalization and Intensive Outpatient Services in a Facility For Mental Health and Substance Abuse treatment.	Not Applicable	No Cost-Share after Deductible is met	30% Coinsurance after Deductible is met
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	Not Applicable	No Cost-Share after Deductible is met **at an Outpatient Hospital Facility** No Cost-Share after Deductible is met **at an Inpatient Facility** No Cost-Share after Deductible is met **at an Mental Health and Substance Abuse Inpatient Facility**	30% Coinsurance after Deductible is met
Prosthetics	Not Applicable	50% Coinsurance after Deductible is met	50% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Abuse services.	Not Applicable	$500 Copayment per day up to $2,000 per admission after Deductible is met	30% Coinsurance after Deductible is met
Retail Health Clinic	Not Applicable	$30 Copayment per visit	30% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Site-of-Service or Freestanding Providers** Member Pays	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Skilled Nursing Facility Up to 90 days per calendar year, limit is combined for Skilled Nursing Facility and Inpatient Rehabilitation.	Not Applicable	$500 Copayment per day up to $2,000 per admission after Deductible is met	30% Coinsurance after Deductible is met

Important Notices about Your Benefits and Cost-Shares

1. **Applicable Benefit Maximums:** All Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined. In addition to the Benefit Maximums listed in the "Schedule of Benefits", the following Benefit Maximums also apply:

    a. **Ambulance Services:** Benefits for non-Emergency Land and Air ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.
    b. **Dental Services:** See the "Dental Services" section for details.
    c. **Donor search charges:** are limited to the 10 best matched donors, identified by an authorized registry.
    d. **Hearing aids:** To aid or compensate for impaired human hearing. Coverage is available 1 per hearing impaired ear every 24 months.
    e. **Outpatient Rehabilitative and Habilitative Therapy Services:**
        - The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.
        - When you get physical, occupational, or speech therapy in the home, the standard physical, occupational, speech therapy visit limit will apply instead of the Home Care limit.
        - Any limits for physical, occupational, and speech therapy will not apply to Autism Spectrum Disorder services.
    f. **Wigs:** Up to 1 wig per Member per benefit period.

2. **Benefit Period:** The Benefit Period for this Plan is Calendar Year. Please see "Definitions" for details.

3. **Deductible Notes:**

    a. When the Deductible applies, you must pay it before benefits begin. Please see the "Schedule of Benefits" to find out when the Deductible applies.
    b. Your Plan has two types of Deductible, the individual and family Deductibles. If you are the only person on your plan, then the individual Deductible applies. If your plan includes you and other family members then both types of Deductibles may apply to you. When anyone on the plan has a health care expense, the money you pay toward the Deductible is credited to both the individual and family Deductibles. The Deductible is considered satisfied for any one member when an individual satisfies his or her individual deductible, prior to receiving benefits that are subject to the deductible. The Plan also begins to pay benefits that are subject to the deductible for the entire family, when the amounts collectively paid by everyone in the family meet the family deductible, even if none of the family members has met the individual deductible.
    c. Copayments and Coinsurance are separate from and do not apply to the Deductible.
    d. The In-Network and Out-of-Network Deductibles are separate and cannot be combined.

4. **Coinsurance Reminder:** Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

5. **Out-of-Pocket Limit Notes:**

    a. The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.
    b. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.
    c. Your Plan has two types of Out-of-Pocket Limit, the individual and family Out-of-Pocket Limits. If you are the only person on your plan, then the individual Out-of-Pocket Limit applies. If your plan includes you and other family members then both types of Out-of-Pocket Limits may apply to you. When anyone on the plan has a health care expense, the money you pay toward the Out-of-Pocket

Limit is credited to both the individual and family Out-of-Pocket Limits. The Out-of-Pocket Limit is considered satisfied for any one member when he or she satisfies his or her individual Out-of-Pocket. The Out-of-Pocket Limit is considered satisfied for the family when the amounts collectively paid by everyone in the family meets the family Out-of-Pocket Limit. Together each family member may contribute to the family Out-of-Pocket Limit, but no family member will contribute more than their individual Out-of-Pocket Limit, and other family members may not need to contribute at all towards the Out-of-Pocket Limit.

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

6. **Mental Health and Substance Abuse Office Visits:** Includes Office Visits, Online visits, telehealth, Outpatient treatment, Partial Hospitalization and Intensive Outpatient Programs in an office setting, and in Home treatment.

7. **Out-of-Network Reminder:** Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.

8. **Primary Care Physician/Provider (PCP):** Each Member should pick a PCP for routine physicals and to help when you are ill or need follow-up care after you receive Emergency Services, or we will assign one. A referral from your Primary Care Provider is not required. Please see "How Your Plan Works" for more details.

9. In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

10. Some services must be approved through prior authorization or precertification. Please see "Getting Approval for Benefits" for details.

11. **Inpatient Services:**

    a. **Hospital Transfers:** If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.

    b. **Hospital Readmissions:** If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.

    c. **Newborn / Maternity Stays:** If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.

12. **Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits**

    a. Each Prescription Drug will be subject to a cost-share (e.g., Copayment / Coinsurance) as described in the "Schedule of Benefits". If your Prescription order includes more than one Prescription Drug, a separate cost-share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost-share or the Maximum Allowed Amount.
    b. No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

13. **Preventive Services:** 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, and http://www.cdc.gov/vaccines/acip/index.html.

How Your Plan Works

Introduction

Your Plan is a PPO plan. This Plan has In-Network and Out-of-Network benefits. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service. If services are denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Selecting a Primary Care Physician / Provider (PCP)

Your Plan requires you to select a Primary Care Physician / Provider (PCP) from our network, or we will assign one. We will notify you of the PCP that we have assigned. You may then use that PCP or choose another PCP from our Provider Directory. Please see "How to find a Provider in the Network" for more details. While you are required to select a PCP, you are not required to visit the selected PCP and you are not required to get a referral for Specialist visits.

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

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

First - Make an Office Visit with Your PCP

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

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

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

- Tell them you are an Anthem Member,

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

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

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

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

In-Network Providers

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

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.

Network Provider Services

For services from In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.
2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please read the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

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

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any applicable Cost-Shares;

2. You may have higher cost-sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

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

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.

  This directory is an interactive tool that helps you locate Providers based on Provider type, specialty, and location. It will also identify if is a Site-of-Service Provider. This information will appear directly under the name of the Physician or Facility and, when applicable, the tool will automatically sort by Benefit Tier and show the Site-of-Service Providers first in your search results.

- 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.

In most cases, there will be a Provider in our Network to treat your specific illness or injury. If there is no In-Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out-of-Network Provider for that service as an Authorized Service.

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.

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost-share.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard", which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card (ID Card)

We will give an Identification Card (ID Card) to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting 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 Booklet. Utilization Review aids 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.

If you have any questions about the Utilization Review process, the medical policies, or guidelines, you may call the Member Services 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:

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a Covered Service under your Plan;
- The service cannot be subject to an Exclusion under your Plan; and
- 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 / Investigational as those terms are defined in this Booklet.

  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 childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. 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.
- **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 has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. 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.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, 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. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

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 that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification. However, you may request a Precertification 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	Responsibility to Get Precertification	Comments
In-Network	Provider	The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	• 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 to not be Medically Necessary.
BlueCard Provider	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or

Provider Network Status	Responsibility to Get Precertification	Comments
		setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, precertification is not required. However, 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.		

Services Requiring Review

Services for which Precertification is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

- All elective/scheduled inpatient Hospital admissions
- Inpatient and Outpatient Facility treatment for Mental Health and Substance Abuse Services, such as:
    - Residential Treatment
    - Partial hospitalization program (PHP)
    - Intensive outpatient treatment programs (IOP)
    - Intensive in-home services
    - Transcranial Magnetic Stimulation (TMS)
- Skilled Nursing Facility and Inpatient Rehabilitation stays
- Center of Medical Excellence (CME) procedures
- Human Organ and Tissue Transplant services, Stem cell/bone marrow transplant (with or without myeloablative therapy) donor leukocyte infusion, and donor search services
- Specialty Drugs and related services in any setting, including, but not limited to: Physician's office, infusion center, outpatient Hospital or clinic, or your home or other residential setting
- Specific outpatient Facility services, including diagnostic treatment and other services
- Specific surgical procedures, wherever performed or the site of surgical procedures, as specified by us (e.g., gastric bypass surgery)
- All elective hip, knee, and shoulder arthroscopic/open sports medicine, outpatient spine surgery and interventional spine pain procedures
- Specific diagnostic procedures, including advanced imaging procedures, wherever performed, such as:
    - Computerized Tomography (CT)
    - Computerized Tomography Angiography (CTA)
    - Magnetic Resonance Imaging (MRI)
    - Magnetic Resonance Angiography (MRA)
    - Magnetic Resonance Spectroscopy (MRS)
    - Nuclear Cardiology (NC)
    - Nuclear technology
    - Positron Emission Tomography (PET)
    - PET and PET/CT Fusion
    - SPECT
    - QTC Bone Densitometry
    - Diagnostic CT Colonography
    - Echocardiogram

- Polysomnography and home portable monitors
- Specialized durable medical equipment– customized equipment
- Ambulance (Air / Water) services for non-Emergency transfers
- Therapy Services, wherever performed, such as:
    - Speech Therapy
    - Physical Therapy
    - Occupational Therapy
    - Autism Services
    - Radiation Therapy
- Transgender services
- Genetic testing
- Infertility Services
- Specialized Formula

For a list of current procedures or level of care requiring Precertification, please call the toll-free number for Member Services printed on your Identification Card.

How Decisions are Made

We 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 "Grievance and External Review Procedures" 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 and Notification**
Request for Medical Services	
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request

Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request
Request for Mental Health and Substance Abuse Services	
Urgent Pre-service Review – Levels of care include: Inpatient Services, Residential Treatment, Partial Hospitalization, or Intensive Outpatient Programs.	24 hours from the receipt of the request
Non-Urgent Pre-service Review – Outpatient Services	15 calendar days from the receipt of the request
Urgent Continued Stay / Concurrent Review	24 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days 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.

Important Information

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 this Plan's Members.

Health Plan Individual Case Management

We have a range of programs designed to provide and/or help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions (the "Program(s)"). Our

Programs provide certain services, coordinate benefits and/or educate Members who agree to take part in them to help meet their health-related needs.

Our 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 Anthem and 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, as appropriate, your chosen authorized representative, treating Doctor(s), and other Providers.

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

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem, and you or your authorized representative agree to all Program requirements in writing. 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 authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. 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 surgery, benefits for your Hospital stay will be described under "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 of Covered Services can be received in several settings, including a Doctor's office, a Walk-In Center, an Urgent Care Facility, 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. Please see the "Schedule of Benefits" for more details on how benefits vary in each setting.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

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, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and a Skilled Nursing Facility, or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. 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. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, except in an emergency, no benefits will be available. Please see the "Important Notices about Your Benefits and Cost-Shares" for the maximum benefit.

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

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Autism Services

Please see "Therapy Services" later in this section.

Behavioral Health Services

Please see "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractor Services

Please see “Therapy Services” later in this section.

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. In any of the following 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 Department of Veterans Affairs.
        - The Department of Defense.
        - The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

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

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

All requests for clinical trials services, including services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

1. The Investigational item, device, or service; or
2. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law. Hospitalization shall, for Routine Patient Care Costs, include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the sponsors of such clinical trial; Out-of-Network Hospitalization will be rendered at no greater cost-share to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

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

Dental Services

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 Estimate

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.

IMPORTANT: If you opt to receive dental services or procedures that are not covered benefits under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with dental services or procedures that are not covered benefits, the dental provider should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

Dental Providers

Every plan has a network of dentists to choose from. You can go to any dentist, whether they're in your network or not. But you'll almost always pay less for the same level of care if you see a dentist in your network. Also, dentists in your network will send claims for care directly to us. When you go out-of-network, you may have to pay up front — then you'll submit claims to us for reimbursement.

For help finding a dentist in your network, log in to anthem.com/mydentalvision and go to Find a Doctor. When it asks for the type of doctor, choose dentist. You can also call the Member Services number on your dental ID card for help.

Pediatric Dental Care For Children Under age 19

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 plan. See the "Schedule of Benefits" under "What You Pay for Covered Services" section for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams – Covered 2 times per 12 months.

Radiographs (X-rays)

- Bitewings – Covered 1 set per 12 months.
- Periapicals
- Full Mouth (Complete Series) or Panoramic – covered 1 time per 36-months

Dental Cleaning (Prophylaxis) – Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months.

Fluoride Treatment including topical application of fluoride or therapeutic fluoride varnish – Covered for members with moderate to high risk of dental decay.

Sealants – Covered 1 time per tooth per 36 months through age 14 on permanent molars only.

Space Maintainers and Recement Space Maintainers.

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

Oral Hygiene Instructions – Covered 1 time per 12 months through age 3.

Basic Services

Fillings (restorations) – Fillings are covered when placed on primary or permanent teeth. There are two kind 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.

Basic Tooth Extractions

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

Major Services

Permanent Crowns Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference, plus any applicable cost-shares.

Prefabricated or Stainless Steel Crowns

Endodontic Services

Root Canals

- Endodontic Therapy on Primary Teeth – Therapeutic Pulpotomy and Pulpal Therapy
- Endodontic Therapy on Permanent Teeth – Root Canal Therapy

Apexification – Coverage for this benefit includes all visits to complete the service.

Periodontal Services

Gingivectomy or Gingivoplasty – This is a surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Gingivectomy covered only for severe side effects caused by medicine.

Oral Surgery Services

Complex Surgical Extractions – Surgical removal of 3rd molars is covered only when symptoms of oral pathology exist.

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

General Anesthesia – 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. Nitrous Oxide is covered for Members under 8 years old, or for Members age 8 and older that have been diagnosed with a behavioral problem.

Prosthodontic Services

Dentures and Partials (removable prosthodontic services)

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) – Covered as long as the appliance (denture, partial or bridge) is the permanent appliance and once 6 months has passed from the initial placement of the appliance.

Recement Fixed Prosthetic – Recementation of Bridge (fixed prosthetic)

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. Your or your orthodontist 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 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:

- 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 given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

Orthodontic Payments – 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 Plan.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made a six month intervals until the treatment is finished or coverage under this plan ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this plan, 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

plan. We will not pay for any portion of your treatment that was given before your effective date under this plan.

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 plan.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan.

Medically Necessary Hospital Dental Services

Your Plan also includes Medically Necessary coverage for anesthesia, nursing, and other related hospital services for inpatient or outpatient hospital dental services, or one day dental services when the treating dentist, oral surgeon and your Primary Care Provider determine the dental services to be Medically Necessary and:

- You have a dental condition complex enough that it requires Inpatient services, Outpatient hospital dental services, or one day dental services; or
- You have a developmental disability that places you at serious risk.

All services must be authorized by us as outlined in the “Getting Approval for Benefits” section.

Diabetes Equipment, Education, and Supplies

Your Plan included coverage for diabetic drugs, supplies and equipment.

Outpatient diabetes self-management training is covered if: prescribed by a licensed health care professional; and performed by: a certified; licensed; or registered health care professional trained in diabetes care; and operating within the scope of their license. Benefits are provided for: 10 hours of initial training; 4 hours of extra training because of changes in the person's condition; and 4 hours of training required by new developments in the treatment of diabetes.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us.

Non-Advanced Radiology - Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Radiology - Diagnostic Imaging Services

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

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

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

Other Diagnostic Services

Benefits include, but are not limited to:

- Blood lead screenings and clinically indicated risk assessments.
- Sleep Studies - 1 complete Sleep Study per lifetime.
- Neuropsychological Testing - Psychological, neuropsychological, and neurobehavioral testing are covered as prescribed by State law.

Dialysis

Please see “Therapy Services” later in this section.

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

The cost-shares listed in the “Schedule of Benefits” only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.

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 as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration.

Hearing aids to aid or compensate for impaired human hearing.

Orthotics

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

Prosthetics

Your 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:

- 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 the Women's Health and Cancer Rights Act.
- 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.
- Cochlear implants.

Artificial Limbs

Your Plan includes benefits for Artificial Limbs and accessories, including a Medically Necessary device that contains a microprocessor and repairs and replacements. Artificial Limbs are devices to replace, in whole or in part, an arm or a leg when they are Medically Necessary for activities of daily living.

Services must be authorized by us as outlined in the "Getting Approval for Benefits" section. See the "Schedule of Benefits" for any applicable Cost-Shares.

Covered Services do not include:

- Artificial Limbs designed exclusively for athletic purposes
- Repair or replacement due to misuse or loss
- Back-up items or items that serve a duplicate purpose.

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.

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

Covered Services do not include items often stocked in the home for general use (e.g. Band-Aids, thermometers, and petroleum jelly) and multi-purpose items that could be used for non-medical reasons (e.g. Tape, surgical gloves, batteries, battery chargers, and cleansing agents).

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.

Emergency Care Services

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

Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

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 women, placing the women’s health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. 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 as may be determined to be Emergencies by us.

Emergency Care

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

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service but you may have to pay the difference between the Out-of-Network Provider’s charge and the Maximum Allowed Amount, as well as any applicable Cost-Shares.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

1. The amount the insured's health care plan would pay for such services if rendered by an In-Network health care provider;
2. The usual, customary and reasonable rate for such services, ("Usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc) or
3. The amount Medicare would reimburse for such services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service.

Habilitative Services

Benefits also include habilitative 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.

Please see "Therapy Services" later in this section for further details.

Home Care Services

Benefits are available for Medically Necessary Covered Services performed by a Home Health Care Agency or other Providers 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 or an Advanced Practice Registered Nurse (APRN) 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 by a licensed health care professional include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services. Please see "Diagnostic Services" earlier in this section.
- 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 or other Provider as approved by us.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)**.** Please see "Therapy Services" later in this section.
- Medical supplies
- Durable medical equipment Please see "Durable medical equipment Services" earlier in this section.
- Hospice care provided in the home. Please see "Hospice Care" later in this section.

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Abuse Services" section below.

While some services may be provided in your home, they will be covered as any other service of your Plan (e.g. Durable Medical Equipment will be covered under your "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" benefit).

Custodial Care, convalescent care, domiciliary care and rest home care are not home health services benefits under this Plan.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These additional Covered Services are covered under other parts of this Plan.

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Cost-shares for the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.

Certain services (e.g., cornea and ventricular assist devices) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet. **Please call our Transplant Department as soon as you**

think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant.

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and bone marrow / stem cell / cord blood transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Please note the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow / stem cells / cord blood is included in the Covered Transplant Procedure benefit regardless of the date of service.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details).

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. When you use an Out-of-Network Transplant Providers benefits will be covered at the Out-of-Network level.

When you chose an Out-of-Network Transplant Provider:

- If the Out-of-Network Transplant Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.
- If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider

agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.

Prior Approval and Precertification

To maximize your benefits, you should call Our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. **You must do this before you have an evaluation and/or work-up for a transplant.** We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if We give a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Please see the “Getting Approval for Benefits” section for how to obtain Precertification.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later requested transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Services

Live Donor Health Service

Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Donor Searches

Your Plan includes one Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per lifetime. The testing must be done at an accredited facility and at the time of testing you must sign a consent form authorizing the results of the testing to be used in the national Marrow Donor Program.

Unrelated donor searches from an authorized, licensed registry for bone marrow / stem cell / cord blood transplants for a Covered Transplant Procedure are covered by when approved through Precertification as described above. Donor search charges are limited to the 10 best matched donors, identified by an authorized registry.

Transportation, Lodging, and Meals

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, lodging for the patient and one companion, and meals. If the Member receiving care is a minor, then reasonable and necessary costs for transportation, lodging, and meals may be allowed for two companions. You must send itemized receipts for transportation, lodging, and meal costs in a form satisfactory to Us when claims are filed. Call Us for complete information.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

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

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

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the 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.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.

- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.
- Treatment for ingestion and accidental consumption of a controlled drug or other substance.

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.

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. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility 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 (Benefits for services for Members who have current symptoms or a diagnosed health problem may be billed in addition to the global fee (e.g., for additional ultrasounds during a high-risk pregnancy) under the "Diagnostic Services" benefit, and may be subject to additional Cost-Shares, based on the setting in which Covered Services are received.); and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal 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. Should a mother and newborn be discharged earlier than the 48 hours, or 96 hours, as applicable, coverage will include a follow-up visit within 48 hours of discharge and an additional follow-up visit within 7 days of discharge. 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.

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" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. The Plan will also cover elective abortions.

Infertility Services

Infertility services are the Medically Necessary expenses of the diagnosis and treatment of infertility.

Covered Services include:

- Diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis.
- Services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
- Covered Services also include Ovulation induction, Intrauterine insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer), and low tubal ovum transfer. However the following limitations apply:
  - Ovulation induction coverage is limited to a lifetime maximum* of 4 cycles;
  - Intrauterine insemination is limited to a lifetime maximum* of 3 cycles; and
  - In-vitro, GIFT, ZIFT and low tubal ovum transfer is limited to a lifetime maximum of two cycles combined with not more than two embryo implantations per cycle-with each fertilization or transfer counting as one cycle.

    *Lifetime maximum for infertility services apply when Member has been continuously covered under this Plan. Benefits for infertility services covered under a prior Plan will not apply to the infertility lifetime maximum.

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:
  - Observation and assessment by a physician weekly or more often,
  - Rehabilitation, therapy, and education.

  Benefits for confinement in a Residential Treatment Facility shall be provided only in the following situations:

  - the insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting; and
  - An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.
- **Outpatient Services** including office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs, Intensive In-Home Behavioral Health Services, Home-based therapeutic interventions for children, extended day treatments, and Observation beds in an acute hospital setting.

  Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a l-Licensed or certified Alcohol and Drug Counselor; or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

  Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a licensed or certified Alcohol and Drug Counselor or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.
- **Online Visits** when available in your area. Covered Services include a 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.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,

- Licensed clinical social worker (L.C.S.W.),
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed or Certified Alcohol and Drug Counselor,
- Licensed professional counselor (L.P.C),
- Licensed Advanced Practice Registered nurse (A.P.R.N.), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

The Facility must be licensed, registered and approved by the Joint Commission on Accreditation of Hospitals and meet specific rules set by us (Anthem BCBS).

Mental health Care does not include:

- intellectual disabilities,
- specific learning disorders,
- motor disorders,
- communication disorders,
- caffeine-related disorders,
- relational problems, and
- other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Nutritional Counseling

Covered Services include the following:

- Outpatient self-management training for the treatment of diabetes including medical nutrition therapy.
- Nutritional Counseling for Eating disorders.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits and Doctor Services

Covered Services include:

- **Office Visits** for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.
- **Home Visits** for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the "Home Care Services" benefit described earlier in this Booklet.
- **Retail Health Clinic Care** for limited basic health care services to Members without an appointment. 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.

- **Walk-In Center Care** for evaluation and treatment of Urgent Care services, routine care, or common illnesses for adults and children on a “walk-in” basis. Please see “Urgent Care Services” later in this section for more details**.**
- **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 (Telemedicine)** see “Telehealth (Telemedicine)” later in this section for more details.
- **Prescription Drugs Administered in the Office**

Orthotics

Please see “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility (Surgical Center),
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, 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,
- Treatment for ingestion and accidental consumption of a controlled drug or other substance.

Pain Management

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

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes 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 an In-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,
    - Colorectal cancer,
    - High blood pressure,
    - Type 2 Diabetes Mellitus,
    - Cholesterol,
    - Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as 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:

    - Women's contraceptives, sterilization treatments, and counseling. This includes Generic 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 a Preventive care benefit when Medically Necessary according to your attending Provider, 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 pump per pregnancy.
    - Screenings and/or counseling, where applicable, including but not limited to; Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

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.

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, but not limited to:

    - 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, and http://www.cdc.gov/vaccines/acip/index.html.

Prosthetics

Please see "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

Benefits include services in a Hospital, freestanding Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see "Therapy Services" in this section for further details.

Respiratory Therapy

Please see "Therapy Services" later in this section.

Sex Reassignment Services

This Plan provides benefits for many of the charges for sex reassignment surgery (also known as Transgender surgery) for Members diagnosed with Gender Dysphoria. Sex reassignment surgery must be approved by us for the type of surgery requested and must be authorized as Medically Necessary. Some conditions apply, and all services must be authorized by us as outlined in the "Getting Approval for Benefits" section.

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.

Smoking Cessation

Please see the "Preventive Care" section in this Booklet.

Specialized Formula and Modified Foods

Specialized Formula is a nutritional formula for children up to age twelve that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration.

Coverage for Specialized Formula is intended for use of dietary management of specific disease when under the medical direction and supervision of a doctor, when such specialized formulas are medically necessary for the treatment of that disease or condition.

Benefits also include Amino acid modified preparations; and low protein modified food products for the treatment of inherited metabolic diseases and cystic fibrosis.

All services must be authorized by us as outlined in the "Getting Approval for Benefits" section.

Speech Therapy

Please see "Therapy Services" later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. 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, ectodermal dysplasia, or other complex craniofacial disorder;
- 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.
- Treatment of fractures including temporomandibular joint (TMJ) dysfunction surgery (for demonstrable joint disease only) or temporomandibular disease (TMD) syndrome. Please see “Temporomandibular Joint (TMJ) and Craniomandibular Joint Services” later in this section.

Your Plan also covers certain oral surgeries for children. Please refer to “Pediatric Dental Care For Children Under age 19” for details.

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.

Reconstructive surgeries, procedures and services:

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

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

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

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

- Mastectomy for Gynecomastia;
- Mandibular/Maxillary orthognathic surgery;
- Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants and
- Port Wine Stain surgery.

Breast Implant Removal Notice

For breast implants which were surgically implanted as a result of a mastectomy, benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants,

benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation will be provided.

Mastectomy Notice

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

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

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

Telehealth (Telemedicine)

Covered Services that are appropriately provided by a Telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Plan. 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.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Please also see “Oral Surgery” under “Surgery” earlier in this section.

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, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Please see the “Schedule of Benefit” and “Important Notices about Your Benefits and Cost-Shares” under Outpatient Rehabilitative and Habilitative Services (Therapy Services) for Cost-Shares and Benefit Limits.

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.

- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Early Intervention Services

Services from birth to age three for early intervention Covered Services for a Member and his/her family members provided as part of an individualized family service plan.

Autism Services

Coverage shall be provided for the Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs) based on an approved treatment plan. Your treatment plan will be reviewed not more than once every six months unless your licensed Physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in your treatment plan.

Covered Services include:

- Behavior Therapy for children up until their 21st birthday, when rendered by an Autism Behavioral Therapy Provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker;
- Prescription drugs prescribed by a licensed Physician, advanced practiced registered nurse, or licensed physician assistant for the treatment of symptoms and co-morbidities of autism spectrum disorders;
- Direct psychiatric or consultative services provided by a licensed psychiatrist or psychologist;
- Occupational, Physical, and Speech therapy provided by a licensed therapist.

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. 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. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, Intravenous and oral antibiotic therapy for the treatment of Lyme Disease, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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, and treatment planning.
- **Respiratory 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.

Transplant Services

Please see "Human Organ and Tissue Transplant earlier in this section.

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. When that happens you can visit your local Walk-In Center or Urgent Care Facility (Urgent Care Center). 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 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.

Vision Services

IMPORTANT: If you opt to receive optometric services or procedures that are not covered benefits under this plan, a participating optometrist may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not covered benefits, the optometrist should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

Pediatric Vision Care For Children Under age 19

These vision care services are covered for Members until the end of the month in which they turn 19. To get the In-Network benefits, you must 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. See the "Schedule of Benefits" under "What You Pay for Covered Services" section for any applicable Deductible, Coinsurance, Copayment, and Benefit Maximum information.

Routine Eye Exam

This Plan 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)

Covered lenses include the following lens options at no additional cost when received In-Network: factory scratch coating, UV coating, standard polycarbonate, standard photochromic, standard anti-reflective coating, gradient tinting, and glass-grey #3 prescription sunglass. Additional upgrade options are available at a discount at an In-Network Provider.

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

You can 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 benefit period. 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** – (Conventional or Disposable) 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
  - Anisometropia of 3D or more
  - For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

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

Low Vision

Low vision is 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 care. They include a comprehensive low vision exam (instead of a routine eye exam), optical / non-optical aids or supplemental testing.

Non Collection Frames / Contact Lenses:

If you choose to upgrade from a collection frame / contact lenses to a non-collection frame / contact lenses, you will be given a credit substantially equal to the cost of the collection frame / contact lenses and will be entitled to any discount agreed upon by the provider and us. Claims for a non-collection frame / contact lenses must be submitted directly to us. Claim forms are available from Blue View Vision's Member Services Center by calling 866-723-0515. Mail your complete claim form to the following address along with the original itemized paid receipt that identifies the frame to Blue View Vision Claims Administration, P.O. Box 8504, Mason, OH 45040-7111.

Adult Vision Care for Members Age 19 and Older

These vision care services are covered for members age 19 and older. To get in-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. See the "Schedule of Benefits" under "What You Pay for Covered Services" section for any applicable Cost-Shares, or allowances, and Benefit Maximum information. An allowance is the amount available for you to apply toward Covered Services.

Routine Eye Exam

This Plan 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) eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28). See the "Schedule of Benefits" section for more information.

Frames

You have an allowance to use toward the purchase of any frame. If the frame you choose is more than your allowance, you will have to pay the difference.

Contact Lenses

You have an allowance to use toward contact lenses. If you choose contact lenses that are more than your allowance, you will have to pay the difference. You can use your 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 benefit period.

- **Elective Contact Lenses** – (Conventional or Disposable) contacts you choose for comfort or appearance;
- **Non-Elective Contact Lenses** –contacts that are 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

- Anisometropia of 3D or more
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

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

Vision Services (All Members / All Ages)

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

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

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 when they 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 benefits (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 (Any step therapy regimen shall be implemented consistent with applicable law),
- 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.

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 Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help 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 “Getting Approval for Benefits” for more details.

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

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. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-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 Prescription 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 Out-of-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.

Please 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 In-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 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 (Any step therapy regimen shall be implemented consistent with applicable law),
- 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 offer

alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services. Such changes are subject to the terms and conditions provided in this Booklet.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Drugs for which Prior Authorization is currently required are below:

1st Tier Unifine Pentips	Element Compact V	Locoid	Safesnap Insulin syringe
2tek	Element Plus	Locoid Lipocream	Saizen
Abilify	Element Test Strips	Lofibra	Saizenprep
Abilify Maintena	Elestat	Lomustine	Samsca
Abraxane	Elidel	Lonsurf	Sandostatin
Abstral	Eligard	Lopid	Sandostatin LAR Depot
Acetaminophen w/Codeine	Eliphos	Loprox	Saphris
Aciphex	Elitek	Lortuss EX	Segluromet
Aciphex Sprinkle	Ellence	Lorzone	Semprex-D
Actemra	Elocon	Lotronex	Sensipar
Acthar H.P.	Eloctate	Lovaza	Sernivo
Acticlate	Emadine	Loxapine Succinate	Seroquel
Actimmune	Embeda	Lucentis	Seroquel XR
Actiq	Embrace	Luliconazole	Serostim
Actoplus MET	Embrace EVO	Lumizyme	Sidekick
Actoplus MET XR	Embrace PRO	Lunesta	Signifor
Actos	Emcyt	Lupaneta Pack	Signifor LAR
Aczone	Emend	Lupron Depot	Siklos
Adapalene	Emflaza	Lupron Depot-PED	Sildenafil Citrate
Adasuve	Empliciti	Lutathera	Silenor
Adcetris	Enablex	Luxiq	Siliq
Adcirca	Enbrel	Luzu	Simcor
Addyi	Endari	Lynparza	Simponi
Adempas	Enlite	Lyrica	Simponi Aria
Adlyxin	Enlite Glucose Sensor	Lyrica CR	Simvastatin
Admelog	Entresto	Macugen	Sipuleucel-T Provenge
Admelog Solostar	Entyvio	Magellan Insulin Safety Syrng	Sitavig
Adoxa	Epclusa	Magellan Insulin Syringe	Sivextro
Advanced Glucose Meter	Epinephrine	Makena	Skelaxin
Advanced Glucose Test Strips	Epipen	Mar-Cof BP	Smart Sense Monitoring System
Advate	Epipen Jr.	Mar-Cof CG	Smart Sense Test Strips
Advicor	Epirubicin HCL	Mavyret	Smartest Eject
Advocate Blood Glucose Monitor	Epogen	Max Blood Glucose Meter	Smartest Persona

Advocate Duo	Epoprostenol Sodium	Max Glucose Test Strips	Smartest Pronto
Advocate Pen Needles	Equetro	Maxi-Comfort	Smartest Protege
Advocate Redi-Code	Erbitux	M-Clear WC	Smartest Test
Advocate Redi-Code Duo	Erivedge	Mekinist	Sodium Phenylbutyrate
Advocate Syringes	Erleada	Mektovi	Sodium Sulfacetamide/Sulfur
Advocate Test Strip	Ertaczo	M-End Max D	Sof-Sensor
Adynovate	Erwinaze	M-End PE	Solaraze
Adzenys ER	Esbriet	Mentax	Soliqua 100-33
Adzenys XR-ODT	Esomeprazole Magnesium	Mepsevii	Soliris
Aerospan	Esomeprazole Strontium	Mesna	Solo V2
Afinitor	Eszopiclone	Mesnex	Solo V2 Test Strips
Afinitor Disperz	Ethyol	Metaxalone	Solodyn
Afrezza	Eucrisa	Metformin HCL	Solosec
Afstyla	Euflexxa	Metformin HCL ER	Soloxide
Agamatrix Amp	Evekeo	Methadone HCL	Solus V2
Aimovig Autoinjector	Evencare	Methadose	Soma
Aimovig Autoinjector (2 pack)	Evencare G2	Methylin	Somatuline Depot
Aktipak	Evencare G3	Methylphenidate ER	Somavert
Ala-Scalp HP	Evencare Mini Glucose Test STR	Metrocream	Sonata
Albenza	Evencare Mini Monitor System	Metrogel	Sovaldi
Aldara	Evoclin	Metrolotion	Sporanox
Aldurazyme	Evolution Blood Glucose Meter	Micro	Sprix
Alecensa	Evolution Test Strips	Microdot	Sprycel
Alimta	Evzio	Miglustat	Standardized Timothy Grass
Aliqopa	Exalgo	Migranow	Steglatro
Allegra-D Rx	Exelderm	Mini Ultra-Thin Ii	Steglujan
Alocril	Exelon	Minilink Real-Time Transmitter	Stelara
Alogliptin	Exjade	Minimed 630g Guardian Start KT	Stivarga
Alogliptin-Metformin	Exondys 51	Minocin	Strensiq
Alogliptin-Pioglitazone	Extavia	Minocycline HCL	Striant
Alomide	Eylea	Minocycline HCL ER	Sublocade
Alosetron HCL	Ez Smart	Mircera	Subsys
Aloxi	Ez Smart Plus	Mitigare	Sucraid
Alphanate	Ezetimibe	Mko (Midazolam-Ketamine-Ondan)	Sumatriptan Succ-Naproxen SOD
Alphanine Sd	Ezetimibe-Simvastatin	Modafinil	Sumavel Dosepro

Alprolix	Fabior	Molindone HCL	Sumaxin
Altoprev	Fabrazyme	Mometasone Furoate	Supartz
Alunbrig	Fanapt	Monoclate-P	Supartz FX
Alvesco	Farxiga	Monodox	Supprelin LA
Ambien	Farydak	Monoject	Sure Comfort
Ambien CR	Fasenra	Monoject Insulin Syringe	Sure Comfort Insulin Syringe
Amcinonide	Faslodex	Mononine	Sure-Fine Pen Needles
Amerge	Fazaclo	Monovisc	Sure-Ject Insulin Syringe
Amifostine	Feiba Nf	Morphabond ER	Sure-Test Easyplus Mini
Ampyra	Fenofibrate	Morphine Sulfate CR	Sutent
Amrix	Fenoglide	Morphine Sulfate ER	Sylatron
Ancobon	Fenoprofen Calcium	Mozobil	Sylvant
Andexxa	Fenortho	Ms Contin	Symbyax
Androderm	Fentanyl	Myalept	Symdeko
Androgel	Fentanyl Citrate	Mydayis	Symproic
Antara	Fentora	Myglucohealth	Synagis
Anusol-Hc	Ferriprox	Mylotarg	Synalar
Apexicon E	Fetzima	Myobloc	Synarel
Apidra	Fexmid	Mytesi	Synjardy
Apidra Solostar	Fiasp	Naftifine HCL	Synjardy XR
Aplenzin	Fiasp Flextouch	Naftin	Synribo
Apokyn	Fibricor	Naglazyme	Synvisc
Aptensio XR	Fibryga	Nalfon	Synvisc-One
Aralast NP	Fifty50 Test Strip	Naprelan	Syprine
Aranesp	Fioricet With Codeine	Nasonex	Tacrolimus
Arcalyst	Fiorinal w/Codeine	Natesto	Tadalafil
Aripiprazole	Firazyr	Natpara	Tafinlar
Aripiprazole ODT	First-Hydrocortisone	Needles	Tagrisso
Aristada	Firvanq	Nerlynx	Takhzyro
Armodafinil	Flebogamma DIF	Nesina	Taltz Autoinjector
Armonair Respiclick	Flector	Neulasta	Taltz Autoinjector (2 pack)
Arthrotec	Flolan	Neupogen	Taltz Autoinjector (3 pack)
Arymo ER	Flolipid	Neutek 2tek Test Strips	Taltz Syringe
Arzerra	Flowtuss	Newtek	Taltz Syringe (2 pack)
Asa-Butalb-Caff-Cod	Flucytosine	Nexavar	Taltz Syringe (3 pack)
Asacol HD	Flunisolide	Nexium Rx	Tanzeum
Ascensia Breeze 2	Fluocinolone Acetonide	Niacor	Tarceva
Ascomp With Codeine	Fluocinonide	Niaspan	Targadox
Asmanex	Fluoroplex	Ninjacof-XG	Targretin

Asmanex Hfa	Fluorouracil	Ninlaro	Tasigna
Assure 4	Fluphenazine Decanoate	Nityr	Tasmar
Assure Id Insulin Safety	Fluphenazine HCL	Nizoral	Tavalisse
Assure Id Pen Needle	Flurandrenolide	Noctiva	Taxotere
Assure Platinum	Fluticasone Propionate	Nolix	Tecentriq
Assure Prism Multi	Follistim AQ	Norditropin Flexpro	Tecfidera
Atralin	Fora D10	Norditropin Nordiflex	Techlite Insulin syringe
Aubagio	Fora D15	Noritate	Techlite Pen Needle
Auryxia	Fora D15g	Nova Max Blood Glucose Meter	Technivie
Austedo	Fora D20	Novoeight	Telcare
Auvi-Q	Fora D40	Novofine	Telcare Bgm
Avandamet	Fora D40-G31 Test Strips	Novofine Autocover	Temodar
Avandia	Fora G20	Novofine Plus	Temovate
Avastin	Fora G30a	Novolin 70-30	Temozolomide
Aveed	Fora Gd50	Novolin N	Temsirolimus
Avita	Fora Gd50 Test Strips	Novolin R	Terumo Insulin Syringe
Avonex Administration pack	Fora Premium V10	Novolog	Test N'go
Avonex Pen	Fora Test N'go Voice	Novolog Flexpen	Test Strips
Axert	Fora Tn'g Voice	Novolog Mix 70-30	Testim
Axiron	Fora Tn'g Voice Test Strips	Novoseven RT	Testopel
Azacitidine	Fora V10	Novotwist	Testosterone
BAL in oil	Fora V10-V12-D10-D20	Noxafil	Testosterone Cypionate
Basaglar Kwikpen U-100	Fora V12	Nplate	Testosterone Enanthate
Bavencio	Fora V20	Nucala	Tetrabenazine
Bebulin	Fora V30a	Nucort	Texacort
Beconase AQ	Foracare Gd20	Nucynta Er	Thalomid
Belbuca	Foracare Gd40	Nuedexta	Thinpro Insulin Syringe
Beleodaq	Foracare Gd40a	Nulojix	Thiola
Belsomra	Foracare Gd40b	Nuplazid	Thiothixene
Bendamustine Hcl	Forfivo XL	Nutropin Aq	Tibsovo
Bendeka	Fortamet	Nutropin Aq Nuspin	Tivorbex
Benefix	Forteo	Nuvigil	Tolak
Benlysta	Fortesta	Nuwiq	Tolcapone
Benzaclin	Fortiscare Blood Glucose Syst	Obizur	Topcare Ultra Comfort
Benzamycin	Fortiscare Glucose Test Strips	Obredon	Topicort
Benzefoam	Fosrenol	Ocaliva	Topiramate ER
Benzefoam Ultra	Freestyle Flash System	Octagam	Torisel
Bepreve	Freestyle Freedom	Octreotide Acetate	Tracleer

Berinert	Freestyle Freedom Lite	Odactra	Tradjenta
Besponsa	Freestyle Insulinx	Odomzo	Tramadol HCL
Betamethasone Dipropionate	Freestyle Insulinx Test Strips	Ofev	Tramadol HCL ER
Betamethasone Valerate	Freestyle Lite Meter	Olanzapine	Tramadol HCL-Acetaminophen
Betaseron	Freestyle Lite Strips	Olanzapine ODT	Treanda
Bevacizumab	Freestyle Lite test strips	Olanzapine-Fluoxetine HCL	Trelegy Ellipta
Bevespi Aerosphere	Freestyle Navigator	Olopatadine HCL	Trelstar
Bexarotene	Freestyle Precision	Olumiant	Tremfya
Bg-Star	Freestyle Precision Neo	Olux	Tresiba Flextouch U-100
Bivigam	Freestyle Precision Neo Meter	Olux-E	Tresiba Flextouch U-200
Blincyto	Freestyle Sidekick Ii	Olysio	Tretin-X
Blood Glucose	Freestyle System	Omega-3 Acid Ethyl Esters	Tretten
Blood Glucose Monitoring	Freestyle Test Strips	Omeppi	Treximet
Blood Glucose Strips	Frova	Omeprazole-Sodium Bicarbonate	Triamcinolone Acetonide
Blood Glucose Test	Frovatriptan Succinate	Omnaris	Trianex
Boniva	Fulphila	Omnitrope	Tricor
Bonjesta	Fulyzaq	On Call Express Meter	Triderm
Bortezomib	Fusilev	On Call Express Test Strip	Tridesilon
Bosulif	G Tussin AC	On Call Plus Meter	Trientine Hcl
Botox	Galafold	On Call Plus Test Strip	Trifluoperazine Hcl
Botox Cosmetic	Gamastan	On Call Vivid Meter	Triglide
Braftovi	Gamastan S-D	On Call Vivid Pal	Triklo
Bravelle	Gammagard Liquid	On Call Vivid Test Strip	Trilipix
Breeze 2	Gammagard S-D	Oncaspar	Trintellix
Brintellix	Gammaked	Onglyza	Triptodur
Budesonide	Gammaplex	Onmel	Trogarzo
Buphenyl	Gamunex-C	Onpattro	True Metrix Air Glucose Meter
Buprenorphine	Gattex	Onzetra Xsail	True Metrix Blood Glucose Mtr
Butalbital Compound w/Codeine	Gazyva	Opana Er	True Metrix Glucose Test Strip
Butalbital/Caff/Apap/Codeine	Ge100 Blood Glucose System	Opdivo	True Metrix Go
Butrans	Ge100 Blood Glucose Test Strip	Opsumit	True2go Blood Glucose System
Bydureon	Gelnique	Optium	Trueplus Insulin Syringe
Bydureon Bcise	Gel-One	Optium EZ	Trueplus Pen Needle
Bydureon Pen	Gelsyn-3	Optumrx	Trueresult Blood Glucose Meter

Byetta	Genotropin	Oralair	Trueresult Blood Glucose Systm
Cabometyx	Genstrip	Orap	Truetest Test Strips
Calcitriol	Genvisc 850	Orencia	Truetrack
Calcium Disodium Versenate	Geodon	Orencia Clickject	Truetrack Blood Glucose System
Calquence	Gilenya	Orenitram ER	Truetrack Smart System
Capcof	Gilotrif	Orfadin	Trulance
Capecitabine	Glassia	Orilissa	Trulicity
Capex Shampoo	Glatiramer Acetate	Orkambi	Trymine CG
Capital w/Codeine	Glatopa	Orthovisc	Tusnel C
Caprelsa	Gleevec	Oseni	Tussigon
Carac	Gleostine	Osmolex ER	Tussionex
Carbaglu	Gluco Navii	Osphena	Tuzistra XR
Carefine Pen Needle	Glucocard 01	Otezla	Tykerb
Caresens N	Glucocard 01 Sensor	Otrexup	Tylenol W/Codeine
Caresens N Voice	Glucocard Expression	Oxiconazole Nitrate	Tymlos
Caretouch Glucose Monitoring	Glucocard Shine	Oxistat	Tysabri
Caretouch Pen Needle	Glucocard Shine XL	Oxycodone HCL ER	Tyvaso
Caretouch Test Strip	Glucocard Vital	Oxycontin	Uloric
Carimune Nf Nanofiltered	Glucocard Vital Sensor	Oxymorphone HCL	Ulticare
Carisoprodol Compound/Codeine	Glucocom Blood Glucose	Oxymorphone HCL ER	Ulticare Insulin syringe
Carisoprodol-Aspirin-Codeine	Glucocom Glucose	Oxytrol	Ultilet Insulin syringe
Celebrex	Glucophage XR	Ozempic	Ultilet Pen Needle
Celecoxib	Glucose Test Strip	Ozurdex	Ultima
Celexa	Glumetza	Paliperidone Er	Ultra Comfort
Cerdelga	Glyxambi	Palonosetron Hcl	Ultracet
Cerezyme	Gmate Smart Meter	Palynziq	Ultram
Chemet	Gmate Smart Starter	Pancreaze	Ultram Er
Chenodal	Gmate Test Strips	Pandel	Ultra-Thin Ii
Cheratussin AC	Gmate Voice Meter	Paradigm Real-Time	Ultratrak Pro
Cheratussin DAC	Gocovri	Parafon Forte Dsc	Ultratrak Ultimate
Chlorpromazine HCL	Gralise	Paricalcitol	Ultravate
Cholbam	Granix	Pataday	Unifine Pentips
Cialis	Grastek	Patanol	Unifine Pentips Plus
Ciclodan	Guaifenesin AC	Paxil	Unistrip1
Cimzia	Guaifenesin DAC	Paxil CR	Uptravi
Cinqair	Guaifenesin w/Codeine	Pazeo	Utibron Neohaler
Cinryze	Guaitussin AC	Pen- Needle	Valchlor

Clarinex	Guardian Link 3	Penlac	Vancocin HCL
Clarinex-D 12 Hour	Guardian Real-Time	Pennsaid	Vancomycin HCL
Cleocin T	Guardian Sensor 3	Pentips	Vanishpoint
Clever Chek Blood Glucose Syst	Guiatussin AC	Perjeta	Vanos
Clever Chek Test Strips	Haegarda	Perphenazine	Vantas
Clever Choice	Halaven	Perseris	Vascepa
Clever Choice Micro	Haldol	Pertzye	Vectibix
Clever Choice Micro Test Strip	Haldol Decanoate	Pexeva	Velcade
Clever Choice Pro	Halog	Pharmacist Choice	Veletri
Clever Choice Talk	Haloperidol	Phenoxybenzamine HCL	Velphoro
Clever Choice Test Strips	Haloperidol Decanoate	Phenylhistine DH	Veltin
Clickfine	Haloperidol Lactate	Phoslo	Venclexta
Clindagel	Harvoni	Phoslyra	Venclexta Starting pack
Clindamycin Phosphate	Healthpro Glucose Monitor	Picato	Ventavis
Clobex	Healthpro Test Strips	Pimozide	Veramyst
Clocortolone Pivalate	Healthy Accents Unifine Pentip	Pioglitazone HCL	Verasens Blood Glucose Meter
Cloderm	Hectorol	Pioglitazone-Glimepiride	Verasens Meter Starter Kit
Clozapine	Helixate FS	Pioglitazone-Metformin	Verasens Test Strip
Clozapine ODT	Hemlibra	Plegridy	Verdeso
Clozaril	Hemofil-M	Poly-Tussin	Versacloz
Cnl 8	Hetlioz	Poly-Tussin AC	Verzenio
Coagadex	Hexalen	Poly-Tussin D	Vfend
Codeine Sulfate	Histex-AC	Pomalyst	Viberzi
Coditussin AC	Hizentra	Praluent Pen	Vibramycin
Coditussin DAC	Horizant	Praluent Syringe	Victoza
Colchicine	Humate-P	Pravachol	Vidaza
Cometriq	Humatrope	Precision PCX	Viekira Pak
Comfort EZ	Humira	Precision PCX Plus	Viekira XR
Concerta	Humira Pediatric	Precision Point Of Care	Viibryd
Contour	Humulin R	Precision Q-I-D	Vimizim
Contour Link	Humulin R U-500 Kwikpen	Precision Xtra	Vimovo
Contour Next	Hyalgan	Prednicarbate	Virtussin AC
Contour Next EZ	Hycamtin	Premier BLU	Virtussin DAC
Contour Next Link	Hycofenix	Premier Test Strip	Visco-3
Contour Next Link 2.4	Hydrocod-Cpm-Pseudoephedrine	Premier Voice	Vistogard
Contour Next One	Hydrocodone Compound	Premium Blood Glucose	Vituz
Contour Next USB	Hydrocodone / Homatropine	Premium Blood Glucose Test	Vivitrol

Control	Hydrocodone-Chlorpheniramine	Premium V10	Vivlodex
Conzip	Hydrocortisone Butyrate	Presto Pro	Vogelxo
Cool Blood Glucose Meter	Hydrocortisone Valerate	Prevacid Rx	Voltaren
Cool Glucose Test Strip	Hydromet	Prevymis	Vonvendi
Copaxone	Hydromorphone ER	Prialt	Voriconazole
Cordran	Hydroxyprogesterone Caproate	Prilosec Rx	Vosevi
Coremino	Hymovis	Pristiq	Votrient
Corifact	Hyqvia	Privigen	Vpriv
Corlanor	Hysingla ER	Pro Comfort Insulin Syringe	Vraylar
Cosentyx 150mg	Ibandronate Sodium	Pro Comfort Pen Needle	Vytorin
Cosentyx 300mg	Ibrance	Pro Voice V8 Glucose Monitor	Wavesense Amp
Cotellic	Iclusig	Pro Voice V8-V9 Test Strip	Wavesense Jazz
Cotempla XR-ODT	Idelvion	Pro Voice V9 Glucose Monitor	Wavesense Presto
Cresemba	Idhifa	Probuphine	Wellbutrin SR
Crestor	Iglucose Blood Glucose Monitor	Pro-Clear	Wilate
Crysvita	Iglucose Test Strip	Pro-Clear AC	Xadago
Cuprimine	Ilaris	Procrit	Xalkori
Cutivate	Ilumya	Proctocort	Xartemis XR
Cuvitru	Iluvien	Procysbi	Xatmep
Cymbalta	Imatinib Mesylate	Prodigy	Xeljanz
Cyramza	Imbruvica	Prodigy Autocode	Xeljanz XR
Cystaran	Imfinzi	Prodigy Insulin syringe	Xeloda
D.H.E.45	Imiquimod	Prodigy No Coding	Xenazine
Daklinza	Imitrex	Prodigy Pocket	Xeomin
Daliresp	Impavido	Prodigy Voice	Xerese
Dapsone	Impoyz	Profilnine	Xermelo
Daraprim	In Control Pen Needle	Profilnine Sd	Xgeva
Darzalex	Increlex	Prolastin C	Xhance
Daytrana	Indocin	Proleukin	Xiaflex
Deferoxamine Mesylate	Infinity	Prolia	Xifaxan
Delzicol	Infinity Test Strips	Promacta	Xigduo XR
Demser	Infinity Voice Glucose Monitor	Promethazine Vc w/Codeine	Xiidra
Denavir	Infinity Voice Test Strip	Promethazine W/Codeine	Ximino
Depen	Inflectra	Promethazine-Phenyleph-Codeine	Xofigo
Depo-Testosterone	Ingrezza	Pro-Red AC	Xolair
Derma-Smoothe-FS	Inlyta	Protonix	Xtampza ER

Dermatop	Insulin Pen Needle	Protopic	Xtandi
Desferal	Insulin- Syringe	Provigil	Xultophy 100-3.6
Desonate	Insupen	Prozac	Xuriden
Desonide	Intermezzo	Prozac Weekly	Xyntha
Desowen	Intrarosa	Psorcon	Xyntha Solofuse
Desoximetasone	Invega	Pulmicort Flexhaler	Xyrem
Desvenlafaxine ER	Invega Sustenna	Purixan	Xyzal
Desvenlafaxine Fumarate ER	Invega Trinza	Qnasl	Yervoy
Detrol	Invokamet	Qtern	Yonsa
Detrol LA	Invokamet XR	Qualaquin	Yosprala
Dexedrine	Invokana	Qudexy XR	Zaleplon
Dexilant	Iophen C-Nr	Quetiapine Fumarate	Zaltrap
Diatrue Plus	Irenka	Quetiapine Fumarate ER	Zanaflex
Dibenzyline	Iressa	Quillichew ER	Zarxio
Diclegis	Istodax	Quillivant XR	Zavesca
Diclofenac Sodium	Itraconazole	Quinine Sulfate	Zecuity
Diclofenac Sodium-Misoprostol	Ixempra	Quintet	Zegerid Rx
Diclozor	Ixinity	Rabeprazole Sodium	Zejula
Differin	Jadenu	Ragwitek	Zelapar
Diflorasone Diacetate	Jadenu Sprinkle	Rasuvo	Zelboraf
Dihydroergotamine Mesylate	Jakafi	Ravicti	Zemaira
Dipentum	Janumet	Rayaldee	Zembrace Symtouch
Diprolene	Janumet XR	Rayos	Zemplar
Diprolene AF	Januvia	Rebif	Zencia
Diskets	Jardiance	Rebif Rebidose	Zenzedi
Ditropan XL	Jentadueto	Rebinyn	Zepatier
Docefrez	Jentadueto XR	Recombinate	Zetia
Docetaxel	Jetrea	Refuah Plus	Zetonna
Dolophine HC;	Jevtana	Relcof C	Ziana
Doptelet	Juxtapid	Relexxii	Zinbryta
Doryx	Jynarque	Relion All-In-One	Zinplava
Doryx MPC	Kadcyla	Relion Confirm	Ziprasidone HCL
Doxercalciferol	Kadian	Relion Confirm-Micro	Zipsor
Doxil	Kalbitor	Relion Micro	Zocor
Doxorubicin HCL Liposomal	Kalydeco	Relion Pen Needles	Zodryl AC 25
Doxycycline Hyclate	Kanuma	Relion Prime	Zodryl AC 30
Doxycycline IR-DR	Kazano	Relistor	Zodryl AC 35
Droplet Pen Needle	Kenalog	Relpax	Zodryl AC 40
Dropsafe Pen Needle	Kerydin	Remicade	Zodryl AC 50

Duac	Keveyis	Remodulin	Zodryl AC 60
Duavee	Kevzara	Renagel	Zodryl AC 80
Duetact	Keytruda	Renflexis	Zodryl DAC 25
Duexis	Khedezla	Renvela	Zodryl DAC 30
Duopa	Kineret	Repatha Pushtronex	Zodryl DAC 35
Dupixent	Kisqali	Repatha Sureclick	Zodryl DAC 40
Duragesic	Kisqali Femara Co-pack	Repatha Syringe	Zodryl DAC 50
Durlaza	Klofensaid LI	Restasis	Zodryl DAC 60
Durolane	Koate	Restasis Multidose	Zodryl DAC 80
Duzallo	Koate-DVI	Retacrit	Zodryl DEC 25
Dyanavel XR	Kogenate FS	Retin-A Micro Pump	Zodryl DEC 30
Dysport	Kombiglyze XR	Retisert	Zodryl DEC 35
Easy Comfort Insulin Syringe	Korlym	Revatio	Zodryl DEC 40
Easy Comfort Pen Needles	Kovaltry	Reveal Blood Glucose Meter	Zodryl DEC 50
Easy Glide Pen Needle	Krystexxa	Reveal Test Strip	Zodryl DEC 60
Easy Plus LI	Kuvan	Revlimid	Zodryl Dec 80
Easy Step	Kynamro	Rexulti	Zohydro ER
Easy Talk	Kyprolis	Rezira	Zoladex
Easy Touch	Lacrisert	Rhinocort Aqua	Zoledronic Acid
Easy Touch Fliplock Insulin	Lansoprazole	Riastap	Zolinza
Easy Touch Glucose Monitor	Lartruvo	Rightest Gm100 System	Zoloft
Easy Touch Insulin Safety	Lastacaft	Rightest Gm300 System	Zolpidem Tartrate
Easy Touch Luer Lock Insulin	Latuda	Rightest Gm550 System	Zolpidem Tartrate ER
Easy Touch Sheathlock Insulin	Lazanda	Rightest Gs100 Test Strips	Zolpimist
Easy Touch Test Strip	Lemtrada	Rightest Gs300 Test Strips	Zomacton
Easy Touch Uni-Slip	Lenvima	Rightest Gs550 Test Strips	Zometa
Easy Trak	Lescol	Riomet	Zomig
Easygluco	Lescol XL	Risperdal	Zomig ZMT
Easygluco Meter Starter Kit	Letairis	Risperdal Consta	Zontivity
Easygluco Plus	Leukine	Risperdal M-Tab	Zorbtive
Easymax	Leuprolide Acetate	Risperidone	Zorvolex
Easymax L	Levoleucovorin Calcium	Risperidone ODT	Zovirax
Easymax N	Levorphanol Tartrate	Rituxan	Z-Tuss AC
Easymax NG	Lexapro	Rixubis	Zurampic
Easymax Speaking	Lialda	Robafen AC	Zutripro
Easymax V2	Liberty Monitor	Robaxin	Zyclara
Ecoza	Liberty Test Strip	Rocaltrol	Zydelig
Edluar	Linezolid	Romidepsin	Zykadia

Effexor XR	Lipitor	Rozerem	Zypitamag
Efudex	Lipodox	Rubraca	Zyprexa
Egrifta	Lipofen	Ruconest	Zyprexa Relprevv
Elaprase	Liptruzet	Rydapt	Zyprexa Zydis
Elelyso	Lite Touch	Rydex	Zytiga
Element Blood Glucose Meter	Livalo	Rynoderm	Zyvox
Element Compact			

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.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Prescription Drugs used to treat infertility.

Where You Can Get Prescription Drugs

In-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.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the "Grievance and External Review Process" section of this Booklet.

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 In-Network 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 "Grievance and External Review Process" section of this Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. 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 or need to determine if your Pharmacy is a Maintenance Pharmacy, 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.

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 a Specialty Pharmacy.

When you use an In-Network 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.

Please note that In-Network Specialty Drugs are only available from an In-Network Specialty Pharmacies and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. If you do not use an In-Network Specialty Pharmacy, benefits will be covered at the Out-of-Network level.

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.

Home Delivery Pharmacy (Mail Order 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. 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.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the Drug;
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

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.

- 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 single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, 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 single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, 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 Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

Please see the "Schedule of Benefits" to determine which tiers apply to your Plan and for details on your cost-shares.

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.

Prescription Drug List

We also have an Anthem 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.

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

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List:

If you or your Doctor believes 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. Please see the “Grievance and External Review Process” section for more information.

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. Please see the “Grievance and External Review Process” section for more information.

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.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Day supply limits for most Prescription Drugs are listed in the “Schedule of Benefits”. However, Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown in the “Schedule of Benefits” due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

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 the 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 number on your member ID card or log on to the website at www.anthem.com.

Drug Cost-Share Assistance Programs

If you participate in certain drug cost-share assistance programs offered by drug manufacturers or other third parties to reduce the cost-share (Copayment, Coinsurance) you pay for certain Specialty Drugs, the reduced amount you pay may be the amount we apply to your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by an In-Network Provider. Your eligibility to participate in such programs is dependent on the programs' applicable terms and conditions, which may be subject to change from time to time. We may discontinue applying such reduced amounts to your cost-share at any given time.

Special Programs

Except when 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.

What's Not Covered

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.

What's Not Covered Under Your Medical Services

1. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, Participation in a Riot or civil disobedience.

2. **Administrative Charges**

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

3. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   - Acupuncture, except as provided for pain management,
   - Hypnosis,
   - Aroma therapy,
   - Massage and massage therapy,
   - Reiki therapy,
   - Herbal, vitamin or dietary products or therapies,
   - Thermography,
   - Orthomolecular therapy,
   - Contact reflex analysis,
   - Bioenergial synchronization technique (BEST),
   - Iridology-study of the iris,
   - Auditory integration therapy (AIT),
   - Colonic irrigation,
   - Magnetic innervation therapy,
   - Electromagnetic therapy,
   - Neurofeedback / Biofeedback.

4. **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.

5. **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 Plan.

6. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
7. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
8. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
9. **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**.**
10. **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. 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.
11. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
12. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.
13. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
14. **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit which resulted in your conviction of a felony. This Exclusion does not apply if: during the time of the crime or attempted crime you had an elevated blood alcohol content or were under the influence of an intoxicating liquor or any drug or both; or your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
15. **Cryopreservation** Charges associated with the Cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
16. **Custodial Care** Custodial Care, unless otherwise required by Federal or State law, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
17. **Delivery Charges** Charges for delivery of Prescription Drugs.
18. **Dental Services** – Coverage is not provided for the following Dental-related services:
    - Dental care for Members age 19 and older, unless covered by the medical benefits of this Plan.

- Dental services or health care services not specifically covered under the Plan (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
- Services of anesthesiologists, unless required by law.
- Anesthesia Services (such as, intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided by dentists 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 Plan.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Plan.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Plan.
- 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 covered by the medical benefits of this Plan.
- 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.
- 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 Plan or received after the coverage under this Plan 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 Plan.
- Athletic mouth guards.
- Implant services, including maintenance or repair to an implant or implant abutment.
- 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.

19. **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.
20. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
21. **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.
22. **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.
23. **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.
24. **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
25. **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Walk-In Center, Urgent Care Facility (Urgent Care Center) or your Primary Care Physician / Provider.
26. **Experimental or Investigational Services** treatment; procedure; facility; equipment; drugs; devices; or supplies. Any services associated with; or as follow-up to any of the above is not a Covered Service.
27. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet.
28. **Eye Exercises** Orthoptics and vision therapy.

29. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
30. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
31. F**oot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
    - Cleaning and soaking the feet.
    - Applying skin creams to care for skin tone.
    - Other services that are given when there is not an illness, injury or symptom involving the foot.
32. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
33. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
34. **Free Care Services** you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence and services from free clinics.
35. **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.
36. **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 Doctor. This Exclusion also applies to health spas.
37. **Home Care**
    - 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.
    - Private duty nursing.
    - Food, housing, homemaker services and home delivered meals.
38. **Infertility Treatment** Infertility procedures not specified in this Booklet.
39. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
40. **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
41. **Medical Equipment, Devices, and Supplies**
    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    - Non-Medically Necessary enhancements to standard equipment and devices.
    - 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 Allowable Amount for a standard item that is a Covered Service, serves the

same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

42. **Medicare** For which benefits are payable under Medicare Parts A and/or B.
43. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
44. **Non-approved Drugs** Drugs not approved by the FDA.
45. **Non-Medically Necessary Services** Unless otherwise required by Federal or State law, services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
46. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet 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.
47. **Off label use** Off label use, unless we must cover it by law or if we approve it.
48. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.
49. **Personal Care and Convenience**
    - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
    - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
    - Home work-out or therapy equipment, including treadmills and home gyms,
    - Pools, whirlpools, spas, or hydrotherapy equipment.
    - Hypo-allergenic pillows, mattresses, or waterbeds,
    - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
50. **Private Duty Nursing** Private Duty Nursing Services.
51. **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.
52. **Reduction in benefits and Penalties** Any reduction in benefits, including Penalties, are not considered a Cost-Share and do not apply to your Out-of-Pocket Limit. Any reduction in benefits or Penalties imposed by another Plan are not reimbursable as a Covered Service under this Plan.
53. **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.

54. **Reversal of Sex Change** Services to reverse a Sex Change.
55. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
56. **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished , ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.
57. **Sex Change** Evaluation, treatment, and procedures related to and performance of sex-change operations including follow-up treatment, care and counseling, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with generally accepted medical standards.
58. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
59. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
60. **Sterilization** Services to reverse an elective sterilization.
61. **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
62. **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures), unless otherwise covered by this plan.
63. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
64. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
65. **Vision Services** We will not pay for services incurred for, or in connection with, any of the items below:
    - For safety glasses and accompanying frames.
    - For two pairs of glasses in lieu of bifocals.
    - For plano lenses (lenses that have no refractive power).
    - Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.
    - Vision services not listed in this Plan.
    - Cosmetic lenses or options, unless specifically listed in this booklet.
    - For services or supplies combined with any other offer, coupon or in-store advertisement.
    - Certain frame brands in which the manufacturer imposes a no discount policy.
66. **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
67. **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY),

Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug unless required by law, such as for pain management. "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. In order for that Prescription Drug to be considered Medically Necessary, the Doctor must substantiate to us, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the Clinically Equivalent Alternative. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
4. **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
5. **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.
6. **Delivery Charges** Charges for delivery of Prescription Drugs.
7. **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 "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
8. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
9. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
10. **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.

11. **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.

12. **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.

13. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

14. **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.

15. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.

16. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services, unless we must cover them under federal law.

17. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.

18. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

19. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.

20. **Non-approved Drugs** Drugs not approved by the FDA.

21. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

22. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet 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.

23. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

24. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

25. **Out-of-Network Pharmacies** Drugs from a Pharmacy that is not in our network. This does not apply to Emergency Care or Authorized Services.

26. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This

includes Prescription Legend Drugs when any version or strength becomes available over the counter, unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative. This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.

27. **Sanctioned or Excluded Providers** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
28. **Sex Change Drugs** Prescription Drugs related to and performance of sex-change operations including follow-up treatment, care and counseling, unless the Member has been diagnosed with gender dysphoria and all Medically Necessary criteria are met as determined by Anthem BCBS in accordance with generally accepted medical standards.
29. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
30. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
31. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

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

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

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 an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-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 an In-Network Provider or visit www.anthem.com.

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

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our managed care fee schedules used with In-Network Providers, which we reserve the right to modify from time to time; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

For Emergency services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be the greatest of the following amounts:

1. The amount the insured's health care plan would pay for such services if rendered by an In-Network health care provider;
2. The usual, customary and reasonable rate for such services, ("Usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc) or
3. The amount Medicare would reimburse for such services.

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

For Covered Services rendered outside Anthem’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan’s non-participating 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 In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-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).

Your cost-share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost-share responsibilities and limitations, or call Member Services to learn how this Booklet's benefits or cost-share amounts may vary by the type of Provider you use.

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

In some instances you may only be asked to pay the lower In-Network cost-sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and unknowingly receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost-share amounts for those Covered Services.

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 Benefit Booklet 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 Booklet's cost-share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost-share of 20% for In-Network services, and 30% for Out-of-

Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- *The Out-of-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. Provided the Deductible has been met, your total out-of-pocket responsibility would be $190 (20% Coinsurance responsibility).*
- *You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-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 an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050.* ***In addition****, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total Out-of-Pocket charge would be $450 plus an additional $1000, for a total of* ***$1450****.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. We also may authorize the In-Network cost-share amounts to apply to a claim for Covered Services if you receive Emergency Care services from an Out-of-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 an Out-of-Network Provider, You may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge, unless (i) You have received a "surprise bill" from an Out-of-Network Provider or (ii) You were required to utilize an Out–of-Network Provider due to network inadequacy pursuant to and in accordance with applicable law. Please contact Member Services for Authorized Services information or to request authorization.

Exception Request Due to Network Inadequacy

Network Inadequacy is when there isn't an In-Network Provider to provide care or treatment for your specific illness or injury, or if there is unreasonable travel or delay to see an In-Network Provider. Please Note that Network Inadequacy does not include when you are temporarily living outside the Service Area (e.g., when you are a Student at School).

Usually there will be a Provider in our Network to treat your specific illness or injury. If you or your Doctor can't find a Provider in our Network or can't find a Network provider that does not involve unreasonable travel or delay, please call Member Services at the phone number on the back of your Identification Card for help.

Member Services will first try to locate an In-Network Provider for you. If due to Network Inadequacy there is no suitable In-Network Provider then you or your Provider may request an exception for an Authorized Service to see an Out-of-Network Provider. You or Your Doctor will be asked to provide information about

your treatment in order to approve the request for Authorized Services from an Out-of-Network provider. We will provide a response to your request within 15 days of receiving all required information necessary to issue a decision.

Approval to see an Out-of-Network Provider as an Authorized Services does not guarantee coverage under your Plan. Services received by an Out-of-Network Provider must be covered under your Plan, be Medically Necessary, and follow any Plan requirements, such as Precertification. Please see the "Getting Approval for Benefits" section for more information.

Upon approval of an Authorized Service for Network Inadequacy, claims for Covered Services will be paid at the In-Network benefit level. This means you will be responsible for any applicable cost-shares under your Plan, however you will not be responsible for the difference between the Maximum Allowable Amount and the amount billed by the Out-of-Network Provider.

If you elect to see an Out-of-Network Provider without obtaining authorization from Anthem, your services will be covered at the Plan's Out-of-Network level. In addition, you may be responsible for paying the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charges, plus any applicable cost-shares.

Surprise Bill

A Surprise bill means a bill for Covered Services, other than emergency care services, received by a Member for services rendered by an Out-of-Network Provider, where such services were rendered by such Out-of-Network Provider at an In-Network facility, during a service or procedure performed by an In-Network Provider or during a service or procedure previously approved or authorized by Anthem and the Member did not knowingly elect to obtain such services from such Out-of-Network Provider.

A Surprise bill does not include a bill for Covered Services received by a Member when an In-Network Provider was available to render such services and the Member knowingly elected to obtain such services from another Provider who was Out-of-Network.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied.**

Paper Claims, for benefits for Covered Services provided to a Member, will be processed within sixty (60) days of the date the claim is received by Anthem. However, if additional information is needed to process and pay the claim, Anthem will send the claimant a written notice within thirty (30) days after receiving the claim, requesting the additional information required to process the claim. Upon receiving the requested information, Anthem will pay the claim within thirty (30) days.

Electronic claims, for benefits for Covered Services provided to a Member, will be processed within 20 days of Anthem receiving them. If the claim does not include all required information, Anthem will send the claimant a written notice requesting the information be sent within 10 days. Upon receiving the requested information, Anthem will pay the claim within 10 days.

Claim Forms

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

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

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you or the Out-of-Network Provider, at our discretion. 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 Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone, 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.

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.

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 out-of-network Emergency services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or 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 Blue Shield 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® Program benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Program 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.

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

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core® Program

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core® Program, 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® Program; 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® Program claim forms you can get international claims forms in the following ways:

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

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

Coordination of Benefits - When Members Are Insured Under More Than One Plan

All benefits provided under this Plan are subject to the Coordination of Benefits provision as described in this Section.

Understanding Coordination of Benefits

Applicability

The Coordination of Benefits (COB) provision applies to this Plan when you have health or dental care coverage under more than one Plan.

If you are covered by this Plan and another Plan, the "Order of Benefit Determination Rules" in this section shall determine which Plan is the primary Plan.

The benefits of this Plan:

- Shall not be reduced when under the "Order of Benefit Determination Rules" this Plan is the primary Plan; but
- May be reduced or the reasonable cash value of any Covered Service provided under this Plan may be recovered from the primary Plan when under the "Order of Benefit Determination Rules" another Plan is the primary Plan. The above reduction is described in the "Effect Of This Plan On The Benefits Policy" Subsection;
- Penalties imposed on you by the primary carrier are not subject to COB;
- You must submit the explanation of benefits from the primary Plan to Anthem within two years of the date of service in order to be eligible for payment under this Coordination of Benefits Section.

Allowable Expense

A Medically Necessary item of expense for health care that is covered at least in part by one or more Plans covering the Member for whom the claim is made, including applicable Cost-Shares, is an Allowable Expense. When this Plan provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

Allowable Expense does not include coverage for:

- Vision care, Prescription Drugs, or hearing aid programs.
- Any reduction in benefits or Penalties imposed by another Plan because you did not comply with the provisions of that Plan, are not reimbursable as a Covered Service under this Plan.
- The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary.
- The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to

contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Claim Determination Period

The Claim Determination Period is your Benefit Period. However, it does not include any part of a Benefit Period during which a person has no coverage under this Plan, or any part of a Benefit Period before the date this COB provision or a similar provision takes effect.

Plan

For the purpose of this Section, a Plan means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

- Group health or dental insurance, group-type coverage, whether fully insured or self-insured, or any other contract or arrangement where a health or dental benefit is provided. This includes prepayment, staff or group practice association health maintenance organization coverage.

- Coverage under a governmental Plan or required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act as amended from time to time). It also does not include any Plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.

- Medical benefits coverage of no-fault and traditional automobile fault contracts, as provided in this Section.

Each contract or other arrangement for coverage as described above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan

A Primary Plan is a Plan whose benefits for a person's health or dental care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either provision below is true:

- The Plan either has no Order of Benefit Determination rules or it has rules which differ from those stated in this Section; or
- All Plans which cover the person use the Order of Benefit Determination rules as stated in this Section and under those rules the Plan determines its benefits first. There may be more than one Primary Plan (for example: two Plans which have no Order of Benefit Determination rules).

When this Plan is the Primary Plan, Covered Services are provided or covered without considering the other Plan's benefits.

Secondary Plan

A Secondary Plan is a Plan which is not a Primary Plan. If you are covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section decide the order in which your benefits are determined in relation to each other. The benefits of the Secondary Plan may take into consideration the

benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this Section, has its benefits determined before those of the Secondary Plan.

When this Plan is the Secondary Plan, benefits for Covered Services under this Plan may be reduced and Anthem may recover from the Primary Plan, or you, the reasonable cash value of the Covered Services provided by this Plan.

Order of Benefit Determination Rules

General Rule

When you receive Covered Services by or through this Plan or is otherwise entitled to claim benefits under this Plan and has followed all Our guidelines and procedures, including Precertification requirements as specified in this Booklet, and the Covered Services are a basis for a claim under another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- The other Plan has rules coordinating its benefits with those described in the Booklet; and
- Both the other Plan's rules and this Plan's coordination rules, as described below, require that this Plan's benefits be determined before those of the other Plan.

Coordination Rules

We determine our order of benefits using the following rules:

Other than a Dependent

The benefits of the Plan which covers the person as a Subscriber (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent.

Dependent Child/Parents Not Separated or Divorced

When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year, but if both parents have the same birthday, the Plan which covered a parent longer is primary. Only the month and day of the birthday are considered.

Dependent Child/Separated or Divorced Parents

When a claim is made for a Dependent child:

- When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody;

- When the parents are divorced and the parent with legal custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent.

The benefit of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

If the specific terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the Plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other Plan which covers the child as a Dependent child. The provisions of this Subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

Active/Inactive Employee

A Plan which covers you as an employee who is neither laid off nor retired (or covers your Dependent) is primary to a Plan which covers you as a laid-off or retired employee (or covers your Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan which covered you longer is primary to the Plan which covered you for a shorter time.

Pediatric Dental Coordination of Benefits (COB)

If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determinations rules in this section apply. When we provide secondary coverage, we will pay the lesser of the balance of the billed charge or what we would pay if we were primary.

Medicare

If you are eligible for Medicare and still covered under this Plan, We will provide the benefits of this Plan, except as required by law. However, these benefits will be reduced to an amount which, when added to the benefits received pursuant to Medicare, may equal, but not exceed the actual charges for services covered in whole or in part by either this Plan or Parts A, B and D of Medicare.

(Note: Certain services may not require Precertification when it is determined that We are the Secondary Plan. Contact Member Services before any services are rendered to determine if such services require Precertification. In the event that a later determination finds that We are the Primary Plan, any services that were obtained without Precertification while We were administering benefits as a Secondary Plan will not require Precertification as would be required under a Primary Plan.)

Effect Of This Plan On The Benefits

1. This Subsection applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this Subsection. Such other Plan or Plans are referred to as “the other Plans”.
2. Reduction in this Plan’s benefits. When this Plan is the Secondary Plan, Anthem will provide benefits under this Plan so that the sum of the reasonable cash value of any Covered Service provided by this Plan and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. We will never pay more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are “excess” or “always secondary” and if this Plan is determined to be secondary under this Plan’s COB provisions, the amount of benefits payable under this Plan shall be determined on the basis of this Plan being secondary. If the non-complying Plan does not provide the information needed by this Plan to determine its benefits within a reasonable time after it is requested to do so, this Plan shall assume that the benefits of the non-complying Plan are identical to its own, and shall pay its benefits accordingly. However this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

Right To Receive And Release Needed Information

Certain information is needed to apply these COB rules. We have the right to decide which information it needs. By enrolling in this Plan you consent to the release of information necessary to apply the COB rules. Anyone claiming benefits under this Plan must furnish information to Us which We determine is necessary for the coordination of benefits.

Facility Of Payment

A payment made or a service provided under another Plan may include an amount which should have been paid or provided under this Plan. If it does, we may pay that amount to the organization which made that payment. Such amount shall then be considered as though it were a benefit paid under this Plan.

Right Of Recovery

If the amount of the payments made by Us is more than it should have paid under this COB provision, or if it has provided services which should have been paid by the Primary Plan, We may recover the excess or the reasonable cash value of the Covered Services, as applicable, from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

The right we have to recover from you shall be limited to the Allowable Expense that you have received from another Plan. Acceptance of Covered Services will constitute consent by you to Our right of recovery. You agree to take all further action to execute and deliver such documents that may be required and do whatever else is necessary to secure Our rights to recover excess payments. Your failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

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 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 having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.
- Get help at any time, by:
  - Contacting Us by calling the Member Services number on your ID card or visiting anthem.com; or
  - Contacting your local insurance department

    Phone: 800-203-3447
    Write: State of Connecticut Insurance Department
    PO Box 816
    Hartford, CT 06142-0816

You have the responsibility to:

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

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

We want to provide high quality benefits and Member Services to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Grievance and External Review Process

You may have questions about your Health benefit plan. Since questions can often be handled informally, these questions may be addressed by contacting Member Services, please call the number on the back of your Identification Card. In addition, information about the following the Grievance and External Review Procedures, also known as the Appeal Process, may be obtained by contacting Member Services.

Member Services

You may have questions about your Health benefit plan. You usually will be able to answer your benefits questions by referring to this Booklet. However, if you need help you can call or write Member Services.

Questions?	Member Services is available to explain policies and procedures; and answer your questions about membership, benefits, or claims.
Member Services Number:	Toll free in and outside of Connecticut – 1 (800) 545-0948 This number can always be found on the back of your Identification Card
Home Office Address:	You may write or visit our home office during normal business hours at Anthem Blue Cross Blue Shield, Member Services, 108 Leigus Road, Wallingford, CT 06492
Normal Business hours:	Monday through Friday – 8:00 a.m. to 5:00 p.m.
What you will need when you call:	Please have your Identification Card with your ID number on hand. If your question involves a claim; we will need to know the date(s) of service, the name of the Provider, and the charges involved.

Rights Available to Members

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

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

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

If you don't agree with our coverage decision, you have the right to ask for a grievance. The review of your grievance may change our previous coverage decision.

Other Helpful Resources

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

Consumer Affairs Division of the Connecticut Insurance Department

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

Connecticut Office of the Health Care Advocate

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

If You Have a Complaint or An Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your plan or a service you have received. In those cases, please call Member Services at the phone number on your ID card. We will try to resolve your complaint informally. If you are not satisfied with the resolution of your complaint, you have the right to file a grievance (also known as an appeal). You must file a grievance within 180 calendar days from the date you get a decision from us that you do not agree with. The review of your grievance may change our previous coverage decision.

Include the following details with your grievance if you have them:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree;
- The specific reason(s) why you don't agree with the decision; and
- Any written comments, documents or other relevant information to support the request.

At any time, you can name someone to act for you. You must do this in writing.

To file a grievance, you, your doctor, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services at the phone number on your ID card. Your grievance should be sent to one of the following addresses:

For medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

For Mental Health and Substance Abuse Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 2100
North Haven, CT 06473-4201

For "Pediatric Dental Care For Children Under age 19" Issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 1122
Minneapolis, Minnesota
53400-0551

For "Pediatric Vision Care For Children Under age 19" or "Adult Vision Care for Members Age 19 and Older" Issues:

Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

How are Grievances Handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review it. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications. All relevant information given to us by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If your grievance involves a substance use or mental health disorder, we will use the required criteria to review your request.

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

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

Before issuing a decision on a grievance of an adverse coverage decision based on medical necessity, we will give you, free of charge, any new or additional evidence relied upon or scientific or clinical

rationale. We will give you this information in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

Standard (Non-urgent) Grievance

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

We will respond to a grievance for a medical necessity decision within 30 calendar days from the date we get the request. If the decision is not based on medical necessity, we will respond within 20 business days from the date we get the request. Our response will be in writing.

Urgent (Expedited) Grievances

An urgent grievance is available if you have not had or are currently receiving services and the timeframe of a standard grievance review could:

- Seriously jeopardize (harm) your life or health;
- Jeopardize your ability to regain maximum function; or
- In the opinion of a health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service or treatment being requested.

We will let you know our decision within 72 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

For urgent grievances related to Mental Health and Substance Abuse disorders please see the next section.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

Mental Health Disorder and Substance Use Disorder

An urgent grievance is also available for:

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

We will let you know our decision within 24 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

External Review

External Review with the Connecticut Insurance Department

If we deny your request for coverage for a health care service or treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us. You may file for external review with the Office of the Insurance Commissioner if a coverage decision involves making judgment as to the medical necessity appropriateness, health care setting, level of care or effectiveness of the health care service or treatment requested. You may file for an external review at any time within 120 days of the date you get an adverse or final adverse decision.

Bypassing Anthem Blue Cross and Blue Shield's internal grievance process:

You may be able to bypass our internal grievance process and file a request for an expedited external review with the Connecticut Insurance Department within 120-days of the date you get a decision from us that you don't agree with if any of the following circumstances apply:

- If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or
- If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; or
- We the health carrier failed to strictly adhere to the requirements with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.
- We the health carrier have waived our internal grievance process.

You, or your provider acting on your behalf with your consent, may also simultaneously file a request for an internal grievance and an urgent external review with the Connecticut Insurance Department Consumer Affairs Unit. You can request an external review if you meet any of the above requirements otherwise you must wait until Denial of the Health Carriers first level of internal appeal. Please contact the State of Connecticut Insurance Department for more information:

Connecticut Insurance Department

Address:	P.O. Box 816 Hartford, CT 06142-0816
Phone:	1-860-297-3910 (local) 1-800-203-3447 (toll-free)

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

An External Review Guide and application are available on the Department's website, www.ct.gov/cid.

Prescription Drug List Exceptions

Please refer to the “Prescription Drug List” section in “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for the process to submit an exception request for Drugs not on the Prescription Drug List.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the final adverse benefit determination.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from the Department of Health and Human Services and Department of Labor.

ERISA Rights

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and you have exhausted all mandatory grievance rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee, member, or retiree of the Group, and:
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the Plan renewal date once they reach 26 years of age. Coverage may be continued past the age limit in the following circumstances:

For those already enrolled Dependents who cannot work to support themselves due to mental or physical handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us.

We may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, we may require you to give us a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may

choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse;
- Subscriber and child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described below.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are not considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through a public exchange operated by the state or federal government as part of

the Patient Protection and Affordable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the Exchange;
- You adequately demonstrate to the Exchange that the health plan under which you are enrolled has substantially violated a material provision of its contract with you;
- You move and become eligible for new qualified health plans;
- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month; or
- The Exchange determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

You must give the Exchange notice within 30 days of the above events if you wish to enroll.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

If at the time of the Effective Date of coverage you or your covered dependents become eligible for coverage under this Plan while inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility, the coverage under this Plan will be effective. To the extent that the costs of hospitalization, inpatient stay or any medical care relating to that hospitalization or inpatient stay are the responsibility of a previous carrier, the payment of these claims will be coordinated with the previous carrier in accordance with State law. You should notify us when an inpatient stay under these circumstances occurs.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 61 days to add the newborn to your Plan.

Note: Although this 61 day requirement does not apply if there is no additional premium required, we still need an application / change form to make sure we have accurate records and are able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; 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.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 60 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 60 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in "Who is Eligible for Coverage" under "Dependents".

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications, or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the "Termination and Continuation of Coverage" section. We will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. The Plan may not be rescinded, cancelled or limited more than 2 years after the effective date of the Plan. The date of rescission shall be the Effective Date of the Plan.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Group.

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Special Rules if Your Group Health Plan is Offered Through an Exchange

If your Plan is offered through an Exchange, either you or your Group may cancel your coverage and/or your Dependent's coverage through the Exchange. Each Exchange will have rules on how to do this. You may cancel coverage by sending a written notice to either the Exchange or us. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or
- 14 days after you ask for coverage to end, if you ask for a termination date more than 14 days before you gave written notice. We may agree in certain circumstances to allow an earlier termination date that you request.

Continuation of Coverage Under State Law

Continuation options will be provided under each of the following circumstances for the period indicated or until you become eligible for other group insurance, except as otherwise stated in this Section.

- As provided by Connecticut law, the Group shall allow you, your spouse and your Dependent children who would otherwise lose coverage under this Plan to choose to continue coverage as described below.
  - Upon termination of the Subscriber's employment, other than as a result of death or the gross misconduct you and your Dependents may continue coverage until the end of 30 months following the day on which he or she ceased to be eligible for coverage under this Plan;
  - Upon the Subscriber's death, his or her Dependents may continue their coverage until the end of 36 months following the day on which they are no longer eligible for coverage under this Plan;
  - Upon dissolution of the Subscriber's marriage, his or her Dependents may continue their coverage until the end of 36 months following the day on which they are no longer eligible for coverage under this Plan;
  - Upon termination of employment, reduction of hours, or leave of absence that results from the Subscriber's eligibility to receive Social Security income, the Subscriber and his or her Dependents may continue coverage until midnight of the day preceding the Subscriber's eligibility for benefits under Title XVIII of the Social Security Act.
- Upon the Subscriber's absence from employment due to illness or injury, the Subscriber and his or her Dependents may continue during the course of such illness or injury or for up to 12 months from the beginning of such absence.
- Upon termination of the Plan by us or the Group, benefits for Covered Services for a Member who was Totally Disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of 12 months following the month in which the Plan was terminated, provided the claim is submitted within one year of termination of the Plan.
- An additional 11 months shall be available to you and members of your family who are enrolled in this Plan who is; determined to be disabled under Title II or Title XVI of the Social Security Act at the time he or she becomes eligible for extended continuation of coverage under Connecticut Continuation Rights, or becomes disabled at any time during the first 60 days of Connecticut Continuation Rights coverage. You and your enrolled Spouse and Dependent children must provide notice of the disability determination to Anthem not later than 60 days after the date of the Social Security Administration's determination, and before the end of the initial 18 months of Connecticut Continuation Rights coverage.

- You are required to provide timely notice to the Group of your election to continue coverage. Except as provided above, if you continue coverage you may be required to remit the applicable premium payment to the Group. Payment of such premiums need not be made on behalf of you by the Group if they are not received by the Group on a timely basis. If you fail to remit such premium your coverage may be terminated.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Subscribers: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months

For Dependents:	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
For Dependent Children:	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:

- The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
- 14 days after completing military service for leaves of 31 to 180 days,
- 90 days after completing military service for leaves of more than 180 days; or

2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the ”What’s Not Covered" section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Assignment

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

Automobile Insurance

To the extent allowed by law, we will not provide benefits under this plan for covered services paid, payable or required to be provided as basic benefits under any no-fault or other automobile insurance policy.

We have the right to:

- Charge the insurer, as allowed under such law, for the value of Covered Services that you are entitled;
- Charge you for the value of Covered Services for which you have received payment from any and all sources, including but not limited to first party payment.
- Reduce the amount we owe to you by the amount that you have received payment from any and all sources, including but not limited to first party payment.
- Apply your benefits under this Plan to the coordination of benefits rules described in the "Coordination of Benefits When Members Are Insured Under More Than One Plan" section, for Covered Services you receive under an automobile insurance policy which provides benefits without regard to fault.
- Consider you, your own insurer if you fail to secure no-fault insurance as required by law. We will reduce your benefits for Covered Services by the amount that would have been covered (e.g., for basic benefits or other benefits provided for injury) if such a no-fault policy had been obtained.
- Require you to follow the guidelines and requirements of this Plan for Covered Services. If your benefits under a no-fault or other automobile insurance policy run out, then we will continue to provide benefits for Covered Services under this Plan provided they would otherwise be covered under this Plan. Please see the "Getting Approval for Benefits" section for more information.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-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 In-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 In-Network Providers for coordination of Member care. In some instances, In-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 In-Network Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

We will use reasonable efforts, and take the same care to preserve the confidentiality of your medical information. We may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying you. Medical information may be released only with your written consent or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. You may access your own medical records.

We may release your medical information to professional peer review organizations and to the Group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Group to conduct the review or audit.

A statement describing our policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Blue Cross Blue Shield dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Connecticut. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, 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 Group for any of Anthem‘s obligations to the Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

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

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the

Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

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

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

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

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

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, 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 payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services.

Payments will not be reduced based on if you are eligible for Medicare by reason of age, disability, or end-stage renal disease, unless you enroll in Medicare. If you enroll in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice

we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or 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).

Policies and Procedures

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

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

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, and encouraging you to update member-related information. 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.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious, or upon the outcome of a Medically Necessary appeal. A Member may utilize all applicable complaint and appeals procedures.

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

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 adjustment 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 for 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.

Unauthorized Use of Identification Card

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

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan 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.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

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.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

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

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back to us by you, or on your behalf, if we have made or if we make a payment for the services you received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

To the extent allowed by law no benefits shall be provided under this Plan for Covered Services paid, payable, or eligible for coverage under any: Workers' Compensation Law; employer's liability; or occupational disease law; denied under a managed Workers' Compensation program as Out-of-Network services; or which, by law, were rendered without expense to you.

We have the right to:

- Charge the entity obligated under such law for the value of Covered Services to which you are entitled.
- Charge you for the value of Covered Services from which you have received payment.
- Reduce the amount we owe to you by the amount that you have received payment.
- Place a lien on any amount we have paid for Covered Services rendered to you in the event that there is a disputed claim between the Group and the designated Workers' Compensation insurer as to whether or not you are entitled to receive Workers' Compensation benefits payments.
- Recover any such amount owed to us as described above in the event that the disputed and/or controverted claim is resolved by financial settlement to the full extent of such settlement.
- Require you to follow the guidelines and requirements of this Plan for Covered Services. If you benefits under Worker's Compensation, employer's liability or occupational disease law run out, then

we will continue to provide benefits for Covered Services under this Plan provided they would otherwise be covered under this Plan. Please see the “Getting Approval for Benefits” section for more information.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Actively at Work

The term Actively At Work means the employee must work at the Employer Group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of an employee and work the minimum number of hours required per week on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Plan.

Ambulatory Surgical Facility (Surgical Center)

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see "Claims Payment" for more details.

Autism Behavioral Therapy Provider

Means Behavioral Therapy provided or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed physician, or a licensed psychologist. "Supervision" means at least 1 hour of face-to-face supervision of the Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

Autism Spectrum Disorders

"Autism spectrum disorders" means the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the

Member's licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Member's diagnosis.

Behavioral Therapy

The term Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: (A) Provided to children less than twenty-one years of age, and (B) provided or under the supervision of an Autism Behavioral Therapy Provider.

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The "Important Notices about Your Benefits and Cost-Shares" under "What You Pay for Covered Services" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum (Benefit Maximum)

The most we will cover for a Covered Service during a Benefit Period.

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 differences from the reference product.

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Clinical Peer(s)

The term means a physician or other health care professional who:

1. holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and

2. for an urgent care review concerning:
    a. a child or adolescent substance use disorder or a child or adolescent mental disorder, holds:
        - a national board certification in child and adolescent psychiatry; or
        - a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or
    b. an adult substance use disorder or an adult mental disorder, holds:
        - a national board certification in psychiatry; or
        - a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

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

Please refer to the "Getting Approval for Benefits" for specific Request Categories.

Clinical Trials

The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, or palliation, or therapeutic intervention for the prevention of cancer, or disabling, or life-threatening chronic disease, in human beings, except that a clinical trial for the prevention of cancer, or disabling, or life-threatening chronic disease, is eligible for coverage only if it involves a therapeutic intervention and is conducted at multiple institutions. A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved as outlined in the "What's Covered Section".

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

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 toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post- Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dentally Necessary Orthodontic Care

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the "Orthodontic Care" section for more

information.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" 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.

Doctor

Please see the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the Group imposes a waiting period, the first day of your waiting period.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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

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

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

   - Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA"); or any other state or federal regulatory agency; and such final approval has not been granted; or

- 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 or Investigational; or otherwise indicate that the safety; toxicity; or efficacy of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service or supply is under evaluation.

2. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem will consider the information described in subsection C. and assess the following:

    - Whether the scientific evidence is conclusory concerning the effects of the service or health outcomes;

    - Whether the evidence demonstrates the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

    - Whether the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives;

    - Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population of whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

3. The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A. and B. may include one or more items from the following list which is not all inclusive:

    - 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) 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

- 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.

4. Anthem 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 or Investigational.

   Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III clinical trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

   In addition, services and supplies for Routine Patient Care Costs in connection with a Cancer Clinical Trial will not be considered Experimental.

Facility

A facility including but not limited to, a Hospital, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered and/or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) as applicable, and/or meet specific rules set by us.

Freestanding Provider

A Provider (excluding Hospitals) that is not part of or owned by a Hospital and bill independently (i.e. not under a hospital's name or ID number.) Certain Site-of-Service Providers and Ambulatory Surgery Facilities (Surgical Centers) meet these criteria and are considered "freestanding." Each participating facility and provider type is subject to specific licensing, accreditation and credentialing requirements. These independent entities provide health care services such as laboratory tests, surgery, radiology and other services and are typically lower cost options for patients.

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 Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem, and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Home Health Care Agency

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

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

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;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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)

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board

charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

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, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maintenance Medications

Please see the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section for details.

Maintenance Pharmacy

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

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

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

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

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

For the purpose of this subsection “not more costly” means services is cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. 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) the service is performed in the least costly setting that is medically appropriate. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Abuse

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.

Mobile Field Hospital

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

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the “What’s Covered” section for details.

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. Please see the "Schedule of Benefits" for details.

Partial Hospitalization

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Participation in a Riot

Actively taking part in a violent disturbance involving two or more persons.

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

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the 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 that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List 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.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.
- Naturopathic Physician (N.D.) legally entitled to engage in the practice of naturopathy.

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

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

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

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription". This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer, unless medically necessary.
- Insulin, diabetic supplies, and syringes.

Prescription Order

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

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, Advanced Practice Registered Nurse (APRN), clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

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 Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Residential Treatment Center / Facility

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

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- 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:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members without an appointment. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Routine Patient Care Costs

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Please see the “What’s Covered” section for details.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Site-of-Service Provider

Site-of-Service (SOS) providers are labs, radiology and imaging centers that meet cost and other criteria established by Anthem from time to time. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a hospital’s name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered “freestanding” Site-of-Service providers.

- An outpatient facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered “Site-of-Service” (“SOS”).

These entities provide health care services such as laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating facility is subject to specific licensing, accreditation and credentialing requirements.

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 on Accreditation of Health Care Organizations 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.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor 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 Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Total Disability (or Totally Disabled)

The term Totally Disabled means that because of an injury or disease the Covered Person is unable to perform the duties of any occupation for which he or she is suited by reason of education, training or experience.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care Facility (Urgent Care Center)

A Facility or delivery system within the Emergency Department or a Free Standing Medical Center licensed to take emergency transports, from whom Urgent Care services may be obtained. Urgent Care is a lower level of complexity than emergency care, in a hospital setting.

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.

Walk-In 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 services.

Plan Notices

Member Satisfaction Information

In a **2018** survey of our Members participating in the **2017** HMO and PPO Managed Care Plans:

Overall, **92.0%** of our HMO Members and **83.5%** of our PPO Members have a positive rating regarding their health plan.

To reach Us during normal business hours (8:00 a.m. – 5:00 p.m.) please call the number on the back of your Identification Card. After normal business hours you may call the same number, and receive information via an automated telephone system. Also be sure to visit our website, www.Anthem.com, for additional resources and information.

Medical Loss Ratio (MLR)

For insurance entities, the "medical loss ratio" (MLR) is defined as the ratio of incurred claims to earned premium for the prior calendar year. The MLR is calculated once in accordance with state and again in accordance with federal laws for managed care HMO plans and PPO/Indemnity plans issued in Connecticut. For **2017**, Anthem's Medical Loss Ratio for state law purposes was **92.8%** for HMO Plans and **85.0%** for PPO/Indemnity Plans. For **2017**, Anthem's MLR for federal law purposes was **85.2** for small group Plans.

Utilization Review Determinations

During **2017**, Anthem's utilization review department determined the following, based on its review of each case relative to Medical Necessity and Covered Services parameters (for Connecticut enrollees only):

Requests for utilization review:	**83,287**
Number of utilization review denials:	**10,414**
Number of appeals of denials:	**741**
Number of denials reversed or negotiated upon appeal:	**314**

To reach Our utilization review department, call (in-state) 1-800-238-2227 or (out-of-state) 1-800-248-2227. Our telephone system is capable of accepting and recording calls received after hours, on weekends and holidays. You will be provided with instructions and may leave a recorded message with detailed information. Your call will be returned during normal business hours no later than one (1) business day from the date on which the call was received or after we receive the details necessary to respond to you.

Member Notification

When your PCP or a Provider leaves the network servicing your plan, we will inform you in writing within 30 days of the date of the Provider's departure.

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. 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)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. 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)

Albanian

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. 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)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。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)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. 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)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. 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

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चिति तथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. 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)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych 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

Este aviso contém informações importantes sobre a sua candidatura ou benefícios. Preste atenção a datas importantes. Poderá ser necessário agir até determinadas datas para manter os seus benefícios ou gerir os custos. 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)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. 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)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. 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)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (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.