INDIVIDUAL HEALTH POLICY

Anthem Gold Pathway X Enhanced HMO 1500/20% ($0 Preferred Virtual Care + $0 Select Drugs)

IMPORTANT NOTICE

This Policy reflects the known requirements for compliance under the Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into Your health insurance Policy.

RIGHT TO EXAMINE

This Policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the Policy will be deemed void from the beginning, and any premium paid on it will be refunded.

GUARANTEED RENEWABLE

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

IMPORTANT NOTICE REGARDING PEDIATRIC DENTAL SERVICES

This Plan does not include Pediatric Dental Services. Pediatric dental coverage is included in some health Plans, but can also be purchased as a standalone product. Please contact Your insurance carrier or Your producer, or seek assistance through www.healthcare.gov., if You wish to purchase pediatric dental coverage or a standalone dental services product.

Welcome to Anthem!

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

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

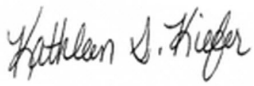
This Policy shall constitute Your entire health benefit Plan under which Covered Services and supplies are provided by Us.

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

If You have any questions about Your Policy, please be sure to call Member Services at the number on the back of Your Identification Card (1-855-748-1804). 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!

Maria Proulx

President and General Manager
New Hampshire



Kathleen S. Kiefer

Corporate Secretary

How to Obtain Language Assistance

Anthem is committed to communicating with Our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Member Services call centers. Simply call the Member Services phone number on the back of Your Identification Card (1-855-748-1804) and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with Us to help with Your needs.

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

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

Contact Us

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

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card (1-855-748-1804).

Please call Anthem Blue Cross and Blue Shield at 1-855-748-1804 **or Fax Member Services at 1-855-414-9998**. The address is:

Visit Us On-line

www.anthem.com

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

Hours of Operation
Monday - Friday
8:00 a.m. to 5:00 p.m. Eastern Time

Conformity with Law

The benefits described in this Policy are provided in accordance with the requirements of the New Hampshire statutes applicable to accident and health insurance and under the jurisdiction of the New Hampshire Insurance Commissioner.

Acknowledgement of Understanding

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

Delivery of Documents

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We 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 (1-855-748-1804) or refer to Our website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (OB/GYN) 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 healthcare professional in Our network who

specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making Referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card (1-855-748-1804) or refer to Our website, www.anthem.com.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under Your Plan:

- Without the need for Precertification;
- Whether the Provider is Network or Out-of-Network.

If the Emergency Services You receive are provided by an Out-of-Network Provider, Covered Services will be processed at the Network benefit level.

Note that if You receive Emergency Services from an Out-of-Network Provider, Your out-of-pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by a Network Provider. However, if the treating Out-of-Network Provider determines You are stable, meaning You have been provided necessary Emergency Services such that Your condition will not materially worsen and the Out-of-Network Provider determines: (i) that You are able to travel to a Network Facility by non-Emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent, You will be responsible for all charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at a Network Facility

When You receive Covered Services from an Out-of-Network Provider at a Network Facility, Your claims will not be covered if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for all Out-of-Network charges for those services. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (I) hospitalists; (J) intensivists; and (K) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to You if Anthem does not have a Network Provider in Your area who can perform the services You require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1) By obtaining Your written consent not later than 72 hours prior to the delivery of services; or
2) If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at a Network Facility, will be calculated using the median Plan Network contract rate that we pay Network Providers for the geographic area where the Covered Service is provided. Any out-of-pocket Cost Shares You pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at a Network Facility will be applied to Your Network Out-of-Pocket Limit.

Appeals

If You receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at a Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, You have the right to Appeal that claim. If Your Appeal of a Surprise Billing Claim is denied, then You have a right to Appeal the adverse decision to an Independent Review Organization as set out in the "If You Have a Complaint or an Appeal" section of this Contract.

Provider Directories

Anthem updates the list of participating providers at least every 30 days as required by New Hampshire law. In accordance with federal law Anthem confirms the list of Network Providers in its Provider Directory every 90 days. If You rely on inaccurate information from Anthem that a Provider was Network on a particular claim, then You will only be liable for Network Cost Share (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network Cost Share will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website at www.anthem.com:

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact State and federal agencies if You believe a Provider has violated the No Surprises Act.

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of Your ID Card:

- Cost Sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing/directory of all Network Providers.

In addition, Anthem will provide access through its website to the following information:

- Network negotiated rates; and
- Historical Out-of-Network rates.

TABLE OF CONTENTS

SCHEDULE OF COST SHARE AND BENEFITS

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

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

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

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

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

What will I pay?

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

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

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

For a detailed explanation of how Your Deductibles and Out-of-Pocket Limits are calculated, see the "How Your Claims Are Paid" section. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	Network Member Pays	Out-of-Network Member Pays
Individual	$1,500	Not Covered
Family	$4,500	Not Covered
The individual Deductible applies to each covered family Member. No one person can contribute more than the individual Deductible amount. Once two or more covered family Members' Deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that Calendar Year.		

Coinsurance	Network Member Pays	Out-of-Network Member Pays
Coinsurance Percentage Unless specified otherwise below	20% Coinsurance	Not Covered

Out-of-Pocket Limit	Network Member Pays	Out-of-Network Member Pays
Individual	$9,100	Not Covered
Family	$18,200	Not Covered
The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year. No one person can contribute more than the individual Out-of-Pocket Limit amount.		

Medical Services

Medical Services	Network Member Pays	Out-of-Network Member Pays
Ambulance Services **Emergency** **Nonemergency** Out-of-Network nonemergency ambulance services are subject to the same Cost Share as Network services up to $50,000 per occurrence. In addition to Your Cost Share, You will be responsible for amounts over the Maximum Allowed Amount except for air ambulance services	$0 Copayment 20% Coinsurance $0 Copayment 20% Coinsurance	$0 Copayment 20% Coinsurance Any balance remaining after the $50,000 per occurrence limit has been met.
Autism Services Physical, Occupational and Speech Therapy limits do not apply to services for treatment of autism	$0 Copayment 20% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Dental Services When provided for Inpatient or Outpatient in a Facility, accidental injury or for certain Members requiring general anesthesia	Cost Share determined by place of service and the Covered Service received	
Diabetes Services Includes management programs, supplies, equipment, and education	Cost Share determined by place of service and the Covered Service received	
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 20% Coinsurance	Not Covered
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 20% Coinsurance	Not Covered
Advanced Imaging Services	$0 Copayment 20% Coinsurance	Not Covered
Doctor (Physician) Visits		
Office Visits with: • Primary Care Physician (PCP) • Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic	Deductible does not apply; $25 Copayment 0% Coinsurance	Not Covered
Virtual Visits with PCP	Deductible does not apply; $25 Copayment 0% Coinsurance	Not Covered
Virtual Visits with PCP from Our Online Provider, LiveHealth Online (whether accessed directly or through Our mobile app, website, or Anthem-enabled devices)	Deductible does not apply; $10 Copayment 0% Coinsurance	Not Covered
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	Deductible does not apply; $35 Copayment 0% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Mental Health Doctor (including in-person and/or Virtual Visits)	Deductible does not apply; $0 Copayment 20% Coinsurance up to a maximum of $25.	Not Covered
Medical Chats and Virtual Visits (including primary care) from Our online Provider K Health, through its affiliated Provider groups, in Our mobile app	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Other Office Services	$0 Copayment 20% Coinsurance	Not Covered
Emergency Room Visits Additional Cost Share determined based on service received	$250 Copayment per Emergency Room Visit; waived if admitted 20% Coinsurance	$250 Copayment per Emergency Room Visit; waived if admitted 20% Coinsurance
Home Care Services	$0 Copayment 20% Coinsurance	Not Covered
Hospice Care	$0 Copayment 20% Coinsurance	Not Covered
Hospital Services Includes Maternity and Reproductive Health Services		
Inpatient Facility	$500 Copayment per admission 20% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 20% Coinsurance	Not Covered
Inpatient and Outpatient Professional Services	$0 Copayment 20% Coinsurance	Not Covered
Medical Supplies, Durable Medical Equipment and Appliances	$0 Copayment 20% Coinsurance	Not Covered

Medical Services	Network Member Pays	Out-of-Network Member Pays
Hearing Aids **External Breast Prostheses** Limited to two prostheses per breast, per Calendar Year **Post-mastectomy Bras** Limited to three bras per Member, per Calendar Year **Wigs and scalp hair prostheses**		
Mental Health and Substance Use Disorder Services **Inpatient Facility**	$500 Copayment per admission 20% Coinsurance	Not Covered
Intensive Outpatient Program Facility and Professional Services	$0 Copayment 20% Coinsurance	Not Covered
Partial Hospitalization Program Facility and Professional Services	$0 Copayment 20% Coinsurance	Not Covered
Preventive Care Services Network services required by law are not subject to Deductible	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Skilled Nursing Facility Limited to a maximum of 100 days per Member, per Calendar Year	$0 Copayment 20% Coinsurance	Not Covered
Surgery **Ambulatory Surgical Center**	$0 Copayment 20% Coinsurance	Not Covered
Therapy Services Outpatient Outpatient Habilitative and Rehabilitative Therapy Services (limits on Physical, Occupational and Speech Therapy services listed below are not combined but separate based on determination of Habilitative Service or Rehabilitative Service).		

Medical Services	Network Member Pays	Out-of-Network Member Pays
The limits do not apply to Mental Health and Substance Use Disorder conditions **Cardiac Rehabilitation**	$0 Copayment 20% Coinsurance	Not Covered
Manipulative Therapy/Chiropractic Services Limited to a maximum of 12 visits per Member, per Calendar Year Cost Shares are determined by place of service and the Covered Service received. Additional Cost Shares may apply. If during the course of one visit, multiple types of service are received, where those types of service carry separate benefit visit limits (e.g., physical therapy and a spinal manipulation), the one visit may count against both limits.	Deductible does not apply; $25 Copayment 0% Coinsurance	Not Covered
Physical Therapy Limited to a maximum of 20 visits per Member, per Calendar Year	$0 Copayment 20% Coinsurance	Not Covered
Occupational Therapy Limited to a maximum of 20 visits per Member, per Calendar Year.	$0 Copayment 20% Coinsurance	Not Covered
Speech Therapy Limited to a maximum of 20 visits per Member, per Calendar Year.	$0 Copayment 20% Coinsurance	Not Covered
Transplant Human Organ & Bone Marrow/Stem Cell/Cord Blood Only Network coverage is available and includes, but is not limited to, transplant, transportation and lodging. **Unrelated Donor Searches** Limited to a maximum of the 10 best matched donors per transplant, identified by an authorized registry.	Cost Share determined by place of service and the Covered Service received	

Medical Services	Network Member Pays	Out-of-Network Member Pays
Urgent Care Center Additional Cost Share determined based on service received	$50 Copayment per Urgent Care visit 20% Coinsurance	$50 Copayment per Urgent Care visit 20% Coinsurance

Prescription Drugs

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

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

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

Your Home Delivery Prescription Drugs does not have two levels of coverage.

Retail Pharmacy Prescription Drugs (Up to a 90-day supply)	**Network Member Pays**		**Non-Network Member Pays**
	Level 1 Pharmacy	**Level 2 Pharmacy**	
Tier 1 (each 30-day supply)	Deductible does not apply; $15.00 Copayment 0% Coinsurance	Deductible does not apply; $30.00 Copayment 0% Coinsurance	Not Covered
Tier 2 (each 30-day supply)	Deductible does not apply; $30.00 Copayment 0% Coinsurance	Deductible does not apply; $45.00 Copayment 0% Coinsurance	Not Covered
Tier 3 (each 30-day supply)	$0 Copayment 40% Coinsurance per Prescription Drug, up to a maximum of $250	$0 Copayment 55% Coinsurance	Not Covered
Tier 4 (each 30-day supply)	$0 Copayment 40% Coinsurance per Prescription Drug, up to a maximum of $500	$0 Copayment 55% Coinsurance	Not Covered

Notes:

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy.

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

For Food and Drug Administration approved contraceptives, up to a 12-month supply of prescribed contraceptives is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

Home Delivery Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 1 (90-day supply)	Deductible does not apply; $37.50 Copayment 0% Coinsurance	Not Covered
Tier 2 (90-day supply)	Deductible does not apply; $75.00 Copayment 0% Coinsurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 40% Coinsurance Per Prescription Drug, up to a maximum of $750	Not Covered
Tier 4 (30-day supply)	$0 Copayment 40% Coinsurance Per Prescription Drug, up to a maximum of $500	Not Covered

Note:

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy and are limited to a 30-day supply.

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

For Food and Drug Administration approved contraceptives, up to a 12-month supply of prescribed contraceptives is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

Pediatric Vision Care Services

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

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

COVERED VISION SERVICES ARE NOT SUBJECT TO THE CALENDAR YEAR DEDUCTIBLE.

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

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

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

HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Policy. It provides details about Network Providers who have entered into an agreement with Anthem and Out-of-Network Providers who have not. You will also find information about how to access a list of Network Providers in Your service area and the importance of choosing a Primary Care Physician.

To find a Network Provider for this Plan, please see “How to Find a Provider in the Network” later in this section.

Your Plan is a HMO Plan. To get benefits for Covered Services, You must use Network Providers, unless We have approved an Authorized Service or if Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another Network Provider, benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of doctors. We have final authority to determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the “If You Have a Complaint or an Appeal” section of this Policy.

- Network Providers - include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, geriatricians or other Network Providers as allowed by Us. The PCP is the doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are Network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by Network Providers:

- You will not be required to file any claims for services You obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Policy.
- When required, prior approval of benefits is the responsibility of the Network Provider. See the “Requesting Approval for Benefits” section.

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

If You receive Covered Services from an Out-of-Network Provider after We failed to provide You with accurate information in Our Provider directory, or after We failed to respond to Your telephone or web-based inquiry within the time required by federal law, Covered Services will be covered at the Network level.

Out-of-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered an Out-of-Network service and not covered under Your Plan. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other

inappropriate activity. Members seeking services from non-participating or Out-of-Network Providers could be balance billed by the non-participating/Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

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

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the doctors, Providers, and Facilities that participate in this Plan's Network.
- Search for a Provider in Our mobile app, website, or Anthem-enabled devices. Details on how to download the app can be found on Our website, www.anthem.com.
- Contact Member Services to ask for a list of doctors and Providers that participate in this Plan's Network based on specialty and geographic area.
- Check with Your doctor or Provider.

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

You do not need a Referral to see a Specialty Care Physician. You can visit any Network Specialist including a behavioral health Provider without a Referral from a Primary Care Physician.

Primary Care Physician (PCP)

The Primary Care Physician (PCP) is a doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine doctors, family practice doctors, general practitioners, or pediatricians. As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

Selecting a Primary Care Physician (PCP)

Your Plan requires You to select a Primary Care Physician 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.

You have direct access for Medical Chats and Virtual Visits with Our online partners through Our mobile app.

PCPs include family practitioner, pediatrician, internist, qualified certified nurse practitioners or other qualified Primary Care Physicians, as required by law, for services within the scope of their license. 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, contact Us or refer to Our website, www.anthem.com.

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

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

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

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. To see a doctor, call their office:

- Tell them You are an Anthem Member,
- Have Your Member Identification Card handy. The doctor's office may ask You for Your 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.

Connect with Us Using Our Mobile App

As soon as You enroll in this Plan, You should download Our mobile app. You can find details on how to do this on Our website, www.anthem.com.

Our goal is to make it easy for You to find answers to Your questions. You can chat with Us live in the app, or contact Us on Our website, www.anthem.com, or through an Anthem-enabled device.

Continuity of Care

If Your Network Provider leaves Our Network for any reason other than termination for cause and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive Network benefits. "Active treatment" includes:

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

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

Identification Card

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

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 Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call 911.
- Your coverage includes benefits for services rendered by Providers other than Network Providers when the condition treated is an Emergency, as defined in this Policy.

Services Must Be Medically Necessary

Anthem will pay for Covered Services only if the services are Medically Necessary. This requirement applies to each and every section of this Policy. The definition of Medical Necessity is mandated under New Hampshire law. Anthem may review services after they have been furnished in order to confirm that they were Medically Necessary. Network Providers in the Service Area are prohibited from billing You for

care that is not Medically Necessary unless:

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

For services received outside the Service Area, You may be responsible for the full cost of services that are not Medically Necessary. No coverage is available for services that are not specifically described as Covered Services in this Policy.

Member Satisfaction Services

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

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

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

Your identification number helps to locate Your important records with the least amount of inconvenience to You. Your identification number is on Your Identification Card. Please be sure to include Your entire identification number (with the three letter prefix) when You call or write. If You have a concern about the quality of care offered to You by a participating or Network Provider (such as waiting times, doctor behavior or demeanor, adequacy of Facilities or other similar concerns), You are encouraged to discuss the concerns directly with the Provider before You contact a Member Services Representative.

Anthem will respond to most of Your questions or requests at the time of Your call or within a few days. Please see the "If You have a Complaint or an Appeal" section for complete information about the internal Appeal procedure. You may have the right to an independent External Review, as summarized in the "If You have a Complaint or an Appeal" section under "External Review."

Please contact Anthem's Member Services about Your membership, benefits, Covered Services, complaints, Plan materials and participating or Network Providers. Anthem's toll-free telephone number (1-855-748-1804) is also on first page of this Policy and on Your Identification Card.	Or, You may write to: Member Services Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, CT 06473-0660
You may choose to contact the State of New Hampshire Insurance Department for assistance at any time during business hours. Call the Insurance Department at: 1-800-852-3416	Or, You may write to: Life, Accident and Health Consumer Affairs Coordinator State of New Hampshire Insurance Department 21 South Fruit Street, Suite 14 Concord, NH 03301

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

Relationship of Parties (Anthem and Network Providers)

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

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

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

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Policy. Utilization Review aids in the delivery of cost-effective healthcare by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

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 part of the review, services that can be safely given to You in a setting with a lower level of care will not be Medically Necessary if they are given in a setting with a higher level 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 setting or place of care 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 approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved 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 in accordance with the definition of Medical Necessity mandated under New Hampshire law.

If You have any questions about Utilization Review process, the medical policies or clinical guidelines, You may call the Member Services phone number on the back of Your Identification Card (1-855-748-1804).

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

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

Types of Reviews

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

  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. For labor/childbirth admissions,

Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require concurrent review.

- **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.

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

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

Who is Responsible for Precertification

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor ("requesting Provider") will get in touch with Us to ask for a Precertification. 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
Network	Provider	The Provider must get Precertification when required
Out-of-Network	Member	The Member has no benefit coverage for an Out-of-Network Provider unless: • The Member gets approval to use an Out-of-Network Provider before the service is given; or • The Member requires an Emergency Care admission (see note below). The Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard® Provider	Member **(Except for Inpatient admissions)**	The Member has no benefit coverage for a BlueCard® Provider unless • The Member gets approval to use a BlueCard® Provider before the service is given; or • The Member requires an Emergency Care admission (see note below). If these are true, then • The Member must get Precertification when required (call Member Services). • The Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary. • **BlueCard®Providers must obtain Precertification for all Inpatient admissions.**

NOTE: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.

How Decisions are Made

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

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card (1-855-748-1804).

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

Decision and Notice Requirements

We will review requests for benefits according to the time frames listed below. The time frames and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws,

We will follow State laws. If You live in and/or get services in a State other than the State where Your Policy was issued, other State-specific requirements may apply. You may call the phone number on the back of Your Identification Card (1-855-748-1804) for more details.

Type of Review	Time Frame Requirement for Decision and Notification
Pre-service Emergent	72 hours from the receipt of request
Pre-service Non-Emergent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at the time of the request and no previous authorization exists	24 hours from the receipt of the request, We may request additional information within the first 24 hours and then extend to 72 hours
Concurrent/Continued Stay Review/ Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Concurrent/Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-Emergent	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 time frame, 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. A verbal notice will be followed by a written notice within two business days.

Important Information

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

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

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

notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line pre-certification list, or contacting the Member Services number on the back of Your Identification Card (1-855-748-1804).

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 Review guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's Members.

Health Plan Individual Case Management

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

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

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

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

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

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

B. Determinations about Experimental/Investigative Services. Anthem makes determinations about whether or not a service is Experimental/Investigative based on the terms of "Experimental/Investigative Services." Anthem's medical policy assists in Our review regarding Experimental/Investigative Services and other issues.

Anthem's medical policy reflects the standards of practice and medical interventions identified as appropriate medical practice. However, the benefits, exclusions and limitations stated in this Policy take precedence over medical policy.

You have the right to Appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigative services. Please see the "If You have a Complaint or an Appeal" section for complete information.

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

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health

outcomes.

- The technology must improve net health outcomes.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational setting.
- The technology must not be an Experimental service.

WHAT IS COVERED

This section describes the Covered Services available under this Policy. Covered Services are subject to all the terms and conditions listed in this Policy, including, but not limited to, benefit maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements.

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

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

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

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

Anthem makes determinations about Precertification, Medical Necessity, Experimental/Investigative services and new technology based on the terms of this Policy, including, but not limited to, the definition of Medical Necessity. The definition of Medical Necessity is mandated under New Hampshire law and is stated in the "Definitions" section. Anthem's medical policy assists in making these determinations. Our medical policy reflects the standards of practice and medical interventions identified as appropriate medical practice. However, the exclusions listed in the "What is Not Covered (Exclusions)" section of this Policy take precedence over medical policy. You have the right to Appeal benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity.

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

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

And one or more of the following are met:

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

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

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

Out-of-Network Providers may bill You for any charges that exceed the Policy's Maximum Allowed Amount except for Surprise Billing Claims. We will reimburse the Out-of-Network ambulance service Provider directly or by a check payable to You and the ambulance service Provider subject to the terms and conditions of this Policy.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

Air and Water Ambulance

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

Air ambulance services for nonemergency Hospital to Hospital transports must be prior authorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Services

Benefits are available for the treatment of pervasive developmental disorder or autism. To determine the Medical Necessity of services, Anthem may require submission of a treatment plan signed by the Member's PCP, an appropriately credentialed treating Specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology or a licensed psychologist with training in child psychology. Anthem will review the treatment plan no more than once every six months unless the Member's Provider changes the treatment plan.

Anthem's definition of Medical Necessity is in the "Definitions" section of this Booklet.

Covered Services include:

- Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advance practice registered nurse, licensed psychologist or licensed clinical social worker.
- Physical, occupational and speech therapy provided by a licensed physical or occupational therapist or by a licensed speech and language pathologist to develop skill or function or to prevent the loss of attained skill or function. As applicable, any visit limits for other physical, speech and occupational therapy, will not apply to physical, occupational or speech therapy to treat pervasive developmental disorder or autism.
- Prescription Drugs, subject to the terms and conditions stated in the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy" section later in this Booklet.
- Applied behavioral analysis that is Medically Necessary to treat pervasive developmental disorder or autism. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

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

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 Policy. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest

scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer clinical trials provided by i-iii below.
    i. The Department of Veterans Affairs.
    ii. The Department of Defense.
    iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration (FDA);
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

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

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

Dental Services

For Medically Necessary dental services resulting from an accidental injury to sound natural teeth and gums. Treatment made necessary due to injury to the jaw and oral structures other than teeth shall be covered without time limit and consistent with terms and conditions of this Policy applicable to medical/surgical services.

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

- Children under the age of 13. The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a Hospital or surgical day care Facility setting. A licensed dentist and the child's PCP must determine in advance that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition. Anthem must approve the care in advance.
- Members who have exceptional medical circumstances or a developmental disability. The exceptional medical circumstance or the developmental disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a Hospital or surgical day care Facility setting. The Member's PCP and Anthem must approve the services in advance.

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

Diabetes Management Programs

To be eligible for benefits, Covered diabetes management programs must be ordered by Your doctor and furnished by a certified, registered or licensed healthcare expert in diabetes management. Covered Services include:

- Individual counseling visits;
- Group education programs and fees required to enroll in an approved group education program;
- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified;
- Screenings for gestational diabetes are covered under "Preventive Care Services."

For information about diabetes education programs or network diabetes education Providers, visit Anthem's website at www.anthem.com, or call Member Services. The toll-free phone number is on the

first page of this Policy and on the back of Your Identification Card (1-855-748-1804).

The following limitations apply to diabetes management services:

- In the service area, benefits are limited to Covered Services furnished by a network diabetes education Provider. Outside the service area, Covered Services must be furnished by a certified, registered or licensed healthcare expert in diabetes management.
- Benefits are available for fees required to enroll in an approved group education program. No benefits are available for costs related to materials, activities or supplies in addition to the enrollment fee.
- Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits. No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Policy. However, coverage is available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity. For additional information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see the "Surgery" section below.

Diagnostic Services Outpatient

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

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Doctor (Physician) Visits

Covered Services include:

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

injury.

Virtual Visits

Covered Services include virtual Telemedicine/Telehealth visits that are appropriately provided through the internet via video. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- **Medical Chats** Covered Services accessed through Our mobile app with a doctor via a text message or chat for limited medical care.
- **"Telemedicine/Telehealth"** means the delivery of healthcare or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing; or secure instant messaging through Our mobile app, website, or Anthem-enabled devices; interactive store and forward (asynchronous) technology; audio-only telephone or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a healthcare Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

  "Remote patient monitoring" means the delivery of home health services using telecommunications technology to enhance the delivery of home healthcare, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

If You have any questions about this coverage, please contact Member Services at the number on the back of Your Identification Card.

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

Retail Health Clinic Care for limited basic healthcare services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Healthcare services are typically given by physician assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

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

Foot Care for podiatry services, including systemic circulatory disease in addition Medically Necessary routine foot care is covered.

Specialist e-Consultations are electronic communications between Your PCP, who is rendering care to You, and a Network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the Network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

Emergency Care Services

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

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

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition", means a medical or behavioral health condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions.

Emergency 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 Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Stabilize, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your doctor calls Us within 48 hours of the admission. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. If You or Your doctor does 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 not be available unless We agree to cover them as an Authorized Service.

Habilitative Services

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

Home Care Services

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

Covered Services include, but are not limited to:

- Visits by a licensed healthcare professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide.
- Infusion Therapy; refer to "Therapy Services Outpatient", later in this section for more information.
- Medical/social services.
- Diagnostic services.

- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Healthcare 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 Healthcare Provider.
- Medical supplies.
- Durable medical equipment.
- Therapy Services.

Hospice Care

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

Covered Services and supplies are those listed below if part of an approved treatment Plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness.

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

In order to receive hospice benefits (1) Your doctor and the hospice medical director must certify that You are terminally ill and have approximately 12 months to live, and (2) Your doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment Plan. You may access hospice care while also 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 hospice must maintain a written treatment Plan on file and furnish it to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Policy.

Hospital Services

Inpatient Hospital Care

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

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

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Treatment for a health problem by a doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two or more doctors during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate doctors.
- A personal bedside exam by another doctor when asked for by Your doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding ambulatory surgical center,
- Mental Health and Substance Use Disorder Facility,
- Other Facilities approved by Us.

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

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

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Once We know of the pregnancy, We will provide the insured in writing regarding the insurer's prenatal, maternity, and postpartum benefits, including, but not limited to, prenatal visits, diagnostic tests, prenatal education, Hospital length of stay, postpartum care, homemaker services, and contraceptive counseling and Referrals. Maternity services incurred prior to Your Effective Date are not covered except where it may be Medically Necessary for prenatal homemaker services when the woman is confined to bed rest or where her doctor has ordered her daily activities to be restricted.

Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of a Certified Midwife under New Hampshire law.
- 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 including physical assessment of mother and infant.
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us.

Note: 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 a vaginal birth, or less than 96 hours after a cesarean (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get Precertification 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.

Also, under federal law, Plans may and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hours or 96 hours stay is treated in a manner less favorable to the mother or newborn than any other portion of the stay.

Please note that benefits are available for complications of pregnancy.

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

Contraceptive Benefits

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

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

Infertility Services

This Policy offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Please see the "What is Not Covered (Exclusions)" section for a listing of excluded services.

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Abortion Services

Benefits for abortions in the case of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

Medical Supplies, Durable Medical Equipment and Appliances

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

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

- Is ordered by a Provider.

Benefits include purchase-only equipment and devices, purchase or rent-to-purchase equipment and devices, and continuous rental equipment and devices. Continuous rental equipment must be approved by Us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device.

Oxygen and equipment for its administration are also Covered Services.

Hearing Supplies

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

- Hearing Aids, including bone anchored hearing aids – Any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing.
- Related services necessary to assess, select, and fit the hearing aid.

Prosthetics

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

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

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by law;
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- Restoration prosthesis (composite facial prosthesis);
- Scalp Hair Prostheses (wigs). A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for You. Benefits are available for scalp hair prostheses for Members who have suffered permanent hair loss as a result of alopecia areata, alopecia totalis, or as a result of accidental injury.

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

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

Medical and Surgical Supplies

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

Diabetic Equipment and Supplies

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a

community source, such as blood donated through a blood bank.

Enteral Formula and Modified Low Protein Food Products

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

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

Mental Health and Substance Use Disorder Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute mental disorders and substance use disorders. Mental health and substance use disorders are conditions that are listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use disorder condition. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s). Covered Services for treatment of addictive substance-related conditions will be based upon ASAM criteria (Treatment Criteria for Addictive Substance Related and Co-Occurring Conditions developed by the American Society of Addiction Medicine) when determining Medical Necessity and setting standards for levels of care for substance use disorder services. Mental Disorders include:

- Schizophrenia and other psychotic disorders such as, but not limited to, paranoia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Obsessive compulsive disorder, including pediatric autoimmune neuropsychiatric disorders
- Panic disorder
- Anorexia nervosa
- Bulimia nervosa and
- Chronic post-traumatic stress disorder
- Pervasive developmental disorder or autism.

Covered Services include the following:

- Inpatient Services in a Network Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification. Your Policy includes clinical stabilization services and short-term Inpatient withdrawal management with prior authorization. Prior authorization requires Your treating clinician to call Anthem's 24-hour hot-line, at the telephone number listed on the back of Your Identification Card (1-855-748-1804), to speak with an Anthem medical clinician or licensed alcohol and drug counselor to make a Medical Necessity determination and assist with placement at the appropriate level of care. The prior authorization decision will be made as soon as practicable at receipt from the treating clinician of the clinical rationale consistent with ASAM criteria, but in no event more than six hours of receiving such information. Until such hotline determination is made, coverage for substance use disorder services shall be provided at an appropriate level of care consistent with ASAM criteria.
- Outpatient services including in-home and office visits and treatment in an Outpatient Department of a Hospital or Outpatient Facility, such as Partial Hospitalization Programs and Intensive Outpatient Programs. Whenever substance use disorder services are to be provided, no prior authorization is required for the first two routine Outpatient visits of an episode of care by an individual for assessment and care.
- Virtual Visits as described under "Doctor (Physician) Visits" subsection.
- Emergency Room Boarding. Following the completion of an involuntary admission certificate for a patient, Anthem will cover board and care for the patient waiting in an Emergency

Department of an acute care hospital located in the state of New Hampshire for each day the Member is waiting for admission for psychiatric treatment to the New Hampshire State Hospital, a community-based designated receiving facility, or a voluntary admission, for up to 21 consecutive days or more until discharged.

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

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed Clinical Social Worker (L.C.S.W.),
- Mental Health Clinical Nurse Specialist (M.H.C.N.S.),
- Licensed Marriage and Family Therapist (L.M.F.T.),
- Licensed Pastoral Psychotherapist,
- Licensed Professional Counselor (L.P.C.) or
- Any agency licensed by the State to give these services, when We have to cover them by law.

Neither Outpatient nor Inpatient substance use disorder services provided by Out-of-Network Providers will be covered under the Policy.

Nutritional Counseling

We provide benefits for nutritional counseling when required for a diagnosed medical condition.

Preventive Care Services

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

Certain Covered Services for Members who have current symptoms or a diagnosed medical condition may be covered under the “Diagnostic Services Outpatient” benefit instead of this benefit, if the symptoms or medical condition do not fall within the State or ACA-recommended preventive services. Additionally, the cost of treatment that results from, but is not part of a preventive procedure, may be subject to Cost Sharing as long as the treatment itself is not identified as a preventive service.

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, including mammograms and low-dose mammograms,
   - Cervical Cancer,
   - High Blood Pressure,
   - Type 2 Diabetes Mellitus,
   - Cholesterol,
   - Child or adult obesity,
   - Colorectal cancer,
   - Behavioral Counseling.

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. Also, benefits are provided for

blood lead level testing for covered members of all ages.

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy." For FDA-approved contraceptives, up to a 12-month supply of prescribed contraceptives is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per Calendar Year or as required by law.
    - Gestational diabetes screening.
5. Preventive care services for tobacco cessation as recommended by the United States Preventive Services Task Force including:
    - Counseling.
    - Prescription Drugs obtained at a Retail or Home Delivery Pharmacy.
    - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
    - Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
    - Aspirin
    - Folic Acid supplement
    - 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 (1-855-748-1804) for more details about these services or view the federal government's websites:

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

Rehabilitative Services

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

Skilled Nursing Facility

When You require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial care is not a Covered Service.

Surgery

Your Plan covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a

doctor's office or an ambulatory surgical center. Covered Services include:

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

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jawbone and is Medically Necessary to attain functional capacity of the affected part;
- Oral/surgical correction of accidental injuries;
- 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.
- Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.

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.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for the following reconstructive services in the manner chosen by the patient and the doctor:

- 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.

Surgery for Conditions Caused by Obesity

Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

craniomandibular joint involves the head and neck muscles.

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

Therapy Services Outpatient

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic services** – Includes benefits for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Early Intervention Services

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

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and drug services that are delivered and administered to You through an I.V. Also includes Total Parenteral Nutrition

(TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility. See the section "Prescription Drugs Administered by a Medical Provider" for more details.

- **Pulmonary Rehabilitation** – Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, non-pressurized 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: Human Organ and Bone Marrow/Stem Cell/Cord Blood

This section describes benefits for certain Covered Transplant Procedures that You get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Policy.

Covered Transplant Procedure

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

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 are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Plan includes 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 transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the 10 best matched donors per transplant, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant Benefit Period starts one day prior to a covered transplant solid organ procedure and one day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants and continues for the applicable case rate/global time period. The number of days will vary depending on the

type of transplant received and the Network transplant Provider agreement. Contact the case manager for specific Network transplant Provider information for services received at or coordinated by a Network transplant Provider Facility. Services received from an Out-of-Network transplant Facility start on the day of the covered transplant procedure and continue to the date of discharge.

Prior Approval and Precertification

In order to maximize Your benefits, You will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Please call Us to find out which Hospitals are Network Transplant Providers. Contact the Member Services telephone number on the first page of this Policy or on the back of Your Identification Card (1-855-748-1804) and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for Precertification prior to the transplant whether 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 "Requesting Approval for Benefits" section for how to obtain Precertification.

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

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the Facility where Your Transplant evaluation and/or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the Facility and lodging for the patient and one companion. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

The above services are covered as Inpatient Services, Outpatient Services or doctor home visits and Office Services depending where the service is performed and are subject to Member Cost Shares.

Urgent Care Services

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

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

Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a Medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration;
- Specific clinical criteria (including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- Specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies);
- Step therapy requiring one drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem which is a list of drugs that have been reviewed and recommended for use based on their quality and cost effectiveness).

Precertification

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

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of Your Identification Card (1-833-201-9560). The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

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

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. A Network

Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

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

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, You will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Pharmacy Member Services at the phone number on the back of Your Identification Card (1-833-201-9560) 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 Pharmacy Member Services at the phone number on the back of Your Identification Card (1-833-201-9560).

Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

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

Certain contracted Retail Pharmacies can fill Your Prescription at the same Cost Shares that apply to the Home Delivery Pharmacy level of benefits. Please ask Your Pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on Your ID Card (1-833-201-9560) for a list of Retail Pharmacies that offer the Home Delivery Pharmacy level of benefits.

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

Prescription Drug Benefits

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

Prior Authorization

Prior Authorization is the process of getting benefits approved before certain Prescriptions can be filled.

Prescribing Providers must obtain Prior Authorization for drug edits in order for You to get benefits for certain drugs. At times, Your Provider will initiate a Prior Authorization on Your behalf before Your

Pharmacy fills Your prescription. At other times, the Pharmacy may make You or Your Provider aware that a Prior Authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

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

You or Your Provider can get the list of the drugs that require Prior Authorization by calling Pharmacy Member Services at the phone number on the back of Your Identification Card (1-833-201-9560) or check Our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

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

Covered Prescription Drugs

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

Benefits are available for the following:

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

Where You Can Get Prescription Drugs

Network Pharmacy

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

with a written request for payment.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, We may require You to select a single Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single Network Pharmacy. We will contact You if We determine that use of a single Network Pharmacy is needed and give You options as to which Network Pharmacy You may use. If You do not select one of the Network Pharmacies We offer within 31 days, We will select a single Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You have a Complaint or an Appeal" section of this Policy.

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single 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 Network Provider. We will contact You if We determine that use of a single Network Provider is needed and give You options as to which Network Provider You may use. If You do not select one of the Network Providers We offer within 31 days, We will select a single Network Provider for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If You have a Complaint or an Appeal" section of this Policy.

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

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

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

Specialty Pharmacy

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

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

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of Your Identification Card (1-833-201-9560) or check Our website at www.anthem.com.

When You Order Your Prescription Through the PBM's Specialty Pharmacy

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

Specialty Pharmacy Program

If You are out of a specialty drug which must be obtained through the PBM's Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72 hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that

it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your specialty drug through the PBM's Specialty Pharmacy and it does not arrive, if Your doctor decides that it is Medically Necessary for You to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow You to get an Emergency supply of medication from a Participating Pharmacy near You. A Member Services representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

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

Maintenance Medication

A Maintenance Medication is a drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number on the back of Your Identification Card (1-833-201-9560) or check Our website at www.anthem.com for more details.

If You are taking a Maintenance Medication, You may purchase Your prescription either from Your local Retail Pharmacy or opt-in to the Home Delivery Pharmacy. You may get the first 30 day supply and one additional 30 day refill at Your local Retail Pharmacy. Before You refill Your prescription a second time, You must contact the Home Delivery Pharmacy to tell them if You want to continue to get refills at the local Retail Pharmacy or through the Home Delivery Pharmacy. Either way, You must contact the Home Delivery Pharmacy and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. CAUTION: You may be required to take additional steps before You can fill Your prescription at the local pharmacy should You seek more than one refill of a Maintenance Medication before registering Your choice through the Home Delivery Pharmacy. You can tell Us Your choice by phone at 1-833-236-6196 or by visiting Anthem's website at www.anthem.com.

When using Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery program, You can call Pharmacy Member Services toll-free at 1-833-201-9560.

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

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, drugs not on the Prescription Drug List, drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the Home Delivery Prescription Drug program Member Services at 1-833-236-6196 for availability of the drug or medication.

What You Pay for Prescription Drugs

Tiers

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

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

- **Tier 1** drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

  Certain low cost drugs, on Tier 1, may be available to Members at no Cost Share. These drugs are listed on Our Prescription Drug List (formulary).

- **Tier 2** drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 3** drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 4** drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

Prescription Drug List

We also have a Prescription Drug List (a formulary) which is a list of 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 Prescription Drug List is developed by Us based upon clinical findings, and where proper, the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over-the-counter medicines, Generic Drugs, the use of one drug over another by Our Members, and where proper, certain clinical economic reasons.

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

We retain the right, at Our discretion, to decide coverage based upon medication dosages, dosage forms, manufacturer and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

This Plan limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other Anthem products. Benefits may not be covered for certain Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. If You are affected by a deletion to the Prescription Drug List, Anthem will notify You in writing at least 45 days before the change is made. Inclusion of a Drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.anthem.com.

Exception Request for a Drug not on the Prescription Drug List

If You or Your doctor believe You need a Prescription Drug that is not on the Prescription Drug List, please have Your doctor or pharmacist get in touch with Us to provide his/her clinical rationale. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and an appropriate alternative to the drugs on the Prescription Drug List. We will make a coverage decision within 48 hours of receiving Your request. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds 48 hours. If We approve the coverage of the drug, coverage

of the drug will be provided for the duration of Your prescription, including refills. If We deny coverage of the drug, You have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 48 hours of receiving Your request. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds 48 hours. If the IRO approves the coverage of the drug, coverage of the drug will be provided for the duration of Your prescription, including refills.

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

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

Drug Utilization Review

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

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost Share and Benefits." In most cases, You must use a certain amount of Your prescription before it can be refilled. In some cases We may let You get an early refill. For example, We may let You refill Your prescription early if it is decided that You need a larger dose. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. 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 Pharmacy Member Services at the number on the back of Your Identification Card (1-833-201-9560).

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 Pharmacy Member Services at the phone number on the back of Your Identification Card (1-833-201-9560).

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. 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 Pharmacy Member Services number on Your Identification Card (1-833-201-9560) or log on to the Member website at www.anthem.com.

Off Label Use

Benefits are available for Prescription Drugs prescribed for off-label use if recognized for treatment of the

indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, no benefits are available for a drug Prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

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

Rebate Impact on Prescription Drugs You Get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn age 19. To get Network benefits, use a Blue View Vision eye care Provider. For help finding one, try "Find a Doctor" on Our website, or call Us at the number on Your Identification Card (1-866-723-0515).

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), progressive or lenticular.

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

Frames

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

Contact Lenses

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

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

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

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses
- High ametropia exceeding -12D or +9D in spherical equivalent
- 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.

Low Vision

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

WHAT IS NOT COVERED (EXCLUSIONS)

In this section You will find a review of items that are not covered by Your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary.

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.

The following services are not covered:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital.
- Services by Out-of-Network Providers unless:
    - the services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
    - the services are approved in advance by Anthem.

Medical Services

Your medical benefits do not cover:

Abortions. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed.

Affiliated Providers. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

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

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
- Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Antigen leukocyte cellular antibody test (ALCAT).
- Cytotoxic test.
- HEMOCODE Food Tolerance System.
- IgG food sensitivity test.
- Immuno Blood Print test.
- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic

medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

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

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described as a Covered Service in this Policy, unless otherwise required by law.

Armed Forces/War. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

Autopsies and Post-mortem Testing.

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 Policy.

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

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims.

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

- Any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-investigational treatments; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Complications of Non-Covered Services. Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. 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.

Compound Drugs. Unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Compound Drug to be considered Medically Necessary, the doctor must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Compound Drug is more medically beneficial than the clinically equivalent alternative.

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

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

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

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

Custodial Care. Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces except as specified as a Covered Service in this Policy.

Dental Implants. For Dental implants except as specified as a Covered Service in this Policy.

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

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

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

- Transplant preparation.
- Initiation of an immunosuppressive.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Doctor or Other Practitioners' Charges. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- For membership, administrative, or access fees charged by doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

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

Us.

Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed, or for any refill given more than one Year after the date of the original Prescription Order.

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

Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by State law, but not by federal law, except for injectable insulin). This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Durable Medical Equipment. Covered Services do not include durable medical equipment except as specified as a Covered Service in this Policy. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specified as a Covered Service in this Policy.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

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

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

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

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

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Policy.

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

Gynecomastia. For surgical treatment of gynecomastia.

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

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements except as specified as a Covered Service in

this Policy or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

Impotency. For services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

Incarceration. For care required while incarcerated in a federal, State or local penal institution or required while in custody of federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility Testing and Treatment. Infertility testing, treatment or procedures not specifically listed in this Policy. Benefits do not include coverage for artificial insemination (AI) services or assisted reproductive technologies (ART) services or the diagnostic tests and Drugs to support AI or ART services. Examples of ART include in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

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

Maintenance Therapy. For maintenance therapy which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement. This exclusion does not apply to “Habilitative Services” in the “What is Covered” section.

Manipulation Therapy – Home. For Manipulation Therapy services rendered in the home except as specified as a Covered Service in this Policy.

Medical Chats Not Provided Through Our Mobile App. Texting or chat services provided through a service other than Our mobile app, website, or Anthem-enabled devices.

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

Medicare Benefits. (1) for which benefits are payable under Medicare Parts A, B and/or D, unless prohibited by law. (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

Missed/Cancelled Appointments. For missed or cancelled appointments.

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

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

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified as a Covered Service in this Policy. This includes, but is not

limited to, suture removal in an Emergency room.

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

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified as a Covered Service in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist.

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Outdoor Treatment Camps and/or Programs and/or Wilderness Programs.

Over-the-Counter. For drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product, or supply, except as specified as a Covered Service in this Policy or as required by law.

Personal Care, Convenience and Mobile/Wearable Devices. For personal hygiene, environmental control, or convenience items including, but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas or similar Facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar Facility;
- Personal comfort and convenience items during an Inpatient stay, including, but not limited to, daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly (flat-head syndrome);
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Physician Stand-by Charges. For stand-by charges of a physician defined as professional physician services requested by another physician and generally involve prolonged physician attendance without direct (face to face) contact with the patient.

Private Duty Nursing. We do not provide benefits for services or charges for Private Duty Nursing.

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

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

Reconstructive Services. Reconstructive services except as specified as a Covered Service in this Policy, or as required by law.

Regression Prevention. For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable, except as specified as a Covered Service in this Policy.

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.

Reversal of Sterilization. We do not provide benefits for services to reverse sterilizations for men or women.

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

Scalp Hair Prostheses (wigs) are not covered for temporary hair loss, except as specified as a Covered Service in this Policy, or for male pattern baldness.

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as specified as a Covered Service in this Policy.

Services Not Appropriate for Virtual Visits. Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

Services Not Listed As Covered. Benefits are not provided for any service, procedure, or supply not listed as a Covered Service in this Policy.

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

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

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

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as specified as a Covered Service in this Policy or as required by law.

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

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

- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy

- Recreational therapy
- Sensory integration therapy (SIT)

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

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

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

Virtual Visits. Virtual Visits do not include the use of facsimile, texting (outside of Our mobile app), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside Our network, benefit Precertification or Provider to Provider discussions except as approved under the “What is Covered” section.

Vision Orthoptic Training. For orthoptics or vision training and any associated supplemental testing.

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Policy. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

Prescription Drugs

Your Prescription Drug benefits do not include or cover:

- Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the PBM.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- 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.
- Compound Drugs. Unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Compound Drug to be considered Medically Necessary, the doctor must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Compound Drug is more medically beneficial than the clinically equivalent alternative.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office/Facility. Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a doctor. This exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy in the office as specified in "Therapy Services Outpatient" or drugs specified in "Medical Supplies, Durable Medical Equipment and Appliances" in the "What is Covered" section – they are Covered Services.
- Drugs not approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or Us.
- Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
- Drugs That Do Not Need a Prescription. Drugs that do not need a Prescription by federal law (including drugs that need a Prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Drugs used for cosmetic purposes.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- Items Covered Under the "Doctor (Physician) Visits" benefit, including allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail, Home Delivery or Specialty Pharmacy" benefit, these items may be covered under "Allergy Services" in the "Doctor (Physician) Visits" benefit.

- Lost or Stolen Drugs. Refills of lost or stolen drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Nutritional or Dietary Supplements. Nutritional and/or dietary supplements, except as described in this Policy 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.
- Onychomycosis Drugs. Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be covered. Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes Prescription Drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the USPSTF, the HRSA or prescribed by Your doctor.
- Prescription Drugs used to treat infertility and infertility hormones.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a Member of Your immediate family, including Your spouse, domestic partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law or self.
- Services We conclude are Not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Sexual Dysfunction Drugs. Drugs to treat sexual or erectile problems.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight Loss Drugs. Any drug mainly used for weight loss.

Pediatric Vision Care

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

- Vision care for Members age 19 and older, except as specified as a Covered Service in this Policy.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified as a Covered Service in this Policy.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified as a Covered Service in this Policy.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified as a Covered Service in this Policy.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.

HOW YOUR CLAIMS ARE PAID

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

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

Cost Sharing Requirements

Cost Sharing is how Anthem shares the cost of healthcare services with You. It means what Anthem is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Copayments, Deductibles and/or Coinsurance (as described below).

Anthem works with doctors, Hospitals, Pharmacies and other healthcare Providers to control healthcare costs. As part of this effort, most Providers who contract with Anthem agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with Providers.

The contracts between Anthem and Our Network Providers include a “hold harmless” clause which provides that You cannot be held responsible by the Provider for claims owed by Anthem for healthcare services covered under this Policy.

Covered Services that are not obtained from a PCP, SCP or another Network Provider, or that are not Authorized Services will not be covered. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

Copayment

Copayment means the fixed dollar amount You may be responsible for when You visit a Provider or fill a prescription for covered Prescription Drugs at the Retail or Home Delivery Pharmacy. In some instances, a Copayment may be required before the Deductible for certain Covered Services. Your Copayment responsibility is shown in Your “Schedule of Cost Share and Benefits.” Whether a Copayment applies to a Covered Service, depends on Your Policy’s benefit design.

Copayments do not accumulate towards the Deductible, however Copayments satisfied in a Calendar Year accumulate towards the Out-of-Pocket Limit.

Coinsurance

Coinsurance means the percentage of the Maximum Allowed Amount for which You are responsible for a specified Covered Service. For example, if Your Coinsurance percentage listed on Your “Schedule of Cost Share and Benefits” is 20%, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan’s benefit design.

Deductible

A Deductible is a specified dollar amount for Covered Services that the Member must pay within each Calendar Year before Anthem reimburses You for Covered Services. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the “Schedule of Cost Share and Benefits” section. A new Deductible applies at the beginning of each Benefit Year.

Deductible Calculation

Each family Member's Maximum Allowed Amounts for Covered Services is applied to his or her individual Deductible. Once two or more family Members' Maximum Allowed Amounts for Covered

Services combine to equal the family Deductible, then no other individual Deductible needs to be met for that Calendar Year. No one person can contribute more than his or her individual Deductible to the family Deductible.

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

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

Out-of-Pocket Limit

The Out-of-Pocket Limit for Covered Services is the sum of the Deductible and Copayment/Coinsurance maximums paid in a Benefit Period. The Out-of-Pocket Limit is the most You pay for Covered Services in a Benefit Year. Once You meet Your Out-of-Pocket Limit, Anthem will cover 100% of the Maximum Allowed Amount for Covered Services for the rest of that Benefit Year.

Out-of-Pocket Limit Calculation

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

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

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

Out-of-Pocket Limit Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out-of-Pocket Limit.

Amounts You incur towards Your Deductible, Copayments and/or Coinsurance count towards the Out-of-Pocket Limit. However, the following will never count towards the Out-of-Pocket Limit, nor will they ever be paid under this Plan:

- Amounts exceeding the Maximum Allowed Amount;
- Amounts over any Plan maximum or limitation; and/or
- Expenses for services not covered under this Policy.

Benefit Period Maximum

Some Covered Services have a maximum number of days or visits that Anthem will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out-of-Pocket Limit. See the "Schedule of Cost Share and Benefits" for those services which have a Benefit Limit.

Balance Billing

Network Providers are prohibited from balance billing. A Network Provider has signed an agreement with Anthem to accept Our determination of the Maximum Allowed Amount or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Policy , e.g., Deductibles (if any) or Coinsurance. When You receive Covered Services from an Out-of-Network Provider, including in an Emergency or when services have been previously authorized, You may be responsible for paying

any difference between the Maximum Allowed Amount and the Provider's actual charges unless You receive a Surprise Billing Claim.

Maximum Allowed Amount

General

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

Reimbursement for services rendered by Network and Out-of-Network Providers is based on Your Policy's Maximum Allowed Amount for the Covered Service that You receive. Please also see "Inter-Plan Programs" provision for additional information.

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

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

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

Generally, services received from an Out-of-Network Provider under this Policy are not covered except for Emergency Care, or when services have been previously authorized by Us. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider either in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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

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

Provider Network Status

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

A Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for Your Policy is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However,

You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding a Network Provider or visit Our website www.anthem.com.

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

Except for Surprise Billing Claims, We will calculate the Maximum Allowed Amount for Covered Services You receive in an Emergency or if previously authorized from an Out-of-Network Provider, using one of the following:

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

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

For services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross and/or 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 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 unless Your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower out of pocket costs to You. Please call Member Services for help in finding a Network Provider or visit Our website at www.anthem.com.

Member Services is also available to assist You in determining Your Plan's Maximum Allowed Amount for a particular service from 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 PBM.

Member Cost Share

For certain Covered Services and depending on Your Plan design, You may be required to pay a part of the Maximum Allowed Amount as Your Cost Share amount (for example, Deductible, Copayment, and/or Coinsurance).

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

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, We may authorize the Network Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the Network Cost Share amounts to apply to a claim for Covered Services if You receive Emergency Services from 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 also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge except for Surprise Billing Claims. Please contact Member Services for Authorized Services information or to request authorization.

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

Example:

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

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

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

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

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 ("non-participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers. Anthem covers only limited healthcare services received outside of the Anthem Service Area. For example, Emergency Care or Urgent Care services received at an Urgent Care Center obtained outside the Anthem Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Services under a value-based program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

D. Non-participating 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, 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 non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating 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 benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care services outside of the United States. Remember to take an up to date health ID Card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global® Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 1-800-810-2583. Or You can call them collect at 1-804-673-1177.

Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care. Please refer to the “Requesting Approval for Benefits” section.

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

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

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

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

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

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

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

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

Claims Procedures

This section explains Anthem’s procedure regarding the submission and processing of claims. For the purposes of this section, Claim Denial means any of the following: Anthem’s denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member’s eligibility for coverage under this Policy. Claim Denial also includes Anthem’s denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of Anthem’s Utilization Review procedures, as well as Anthem’s failure to cover a service for which benefits are otherwise provided based on Anthem’s

determination that the service is Experimental, Investigative or not Medically Necessary or appropriate.

Post-Service Claims

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

A. Time Limit for Submitting Post-Service Claims. In order for Anthem to make payments for Post-Service Claims, Anthem must receive Your claim for benefits within 180 days after You receive the service. Otherwise, benefits will be available only if:

- It was not reasonably possible to submit the claim within the 180 day period, and
- The claim is submitted as soon as reasonably possible after the 180 day period.

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

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

Claims for services furnished by a New Hampshire Provider will be processed according to the terms of New Hampshire law. If eligible for benefits, clean written claims will be processed within 30 calendar days of receipt. Clean electronic claims will be paid within 15 calendar days of receipt. If We deny payment or delay processing, We will notify the New Hampshire Provider within 15 days of receipt. This notice will be mailed to the Subscriber if the Provider is a New Hampshire Out-of-Network Provider. The notice will include the reason for denial or delay and an explanation of any additional information We need to complete processing. Upon Our receipt of all of the requested additional information, We will process the claim within 45 calendar days. If We don't provide the notice that additional information is needed, the claim shall be treated as a clean claim.

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

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

Pre-Service Claims

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

No fees for submitting a Pre-Service Claim will be assessed against You or Your authorized

representative. You may authorize a representative to submit or pursue a Pre-Service Claim or benefit determination by submitting Your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Member Services phone number shown on the first page of this Policy or on the back of Your Identification Card (1-855-748-1804). Exception: For Urgent Care Claims, Anthem will consider a healthcare professional with knowledge of Your condition (such as Your treating doctor) to be Your authorized representative without requiring Your written acknowledgment of the representation.

A. Time Limit for Submitting Pre-Service Claims. Unless it is not reasonably possible for You to do so, Pre-Service Claims must be submitted within the applicable time frames stated in this Policy. For example, You must request Precertification at least seven days before *Y*ou begin a planned Inpatient admission and within 48 hours after an Emergency Inpatient admission. Please see the "Requesting Approval for Benefits" section for information on Precertification.

B. Pre-Service Claim Processing.

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

- For non-Urgent Claims, We will make a Pre-Service Claim determination within a reasonable time period, but in no event more than 15 days after receipt of the claim, unless You or Your authorized representative fail to provide Us with the information We need to make a determination. In the case of such failure, Anthem will notify You within five days after receipt of the claim.
- For Urgent Care Claims, We will make a Pre-Service Claim determination as soon as possible, taking into account the medical exigencies, but in no event later than 72 hours after receipt of the claim, unless You or Your authorized representative fail to provide Us with the information We need to make a determination. In the case of such failure, Anthem will notify You within 24 hours after receipt of the claim.
- For Claims Relating to the Extension of an Ongoing Course of Treatment and Involving a Question of Medical Necessity, We will make a Pre-Service Claim determination within 24 hours of receipt of the claim, provided that You make the claim at least 24 hours before the approved treatment period expires. If You fail to provide sufficient notice or information, We will notify You within 24 hours after receipt of the claim. Coverage for the services will not be terminated until You are notified of Our determination.

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

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

- The specific reason(s) for the determination, including the specific provision of this Policy on which the determination is based.
- A statement of Your right to access the internal Appeal Process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received Emergency Services, but who has not been discharged from a Facility, We will include a description of the expedited review process.
- The name and credentials of Anthem's Medical Director, including board status and the State or States where the Medical Director is currently licensed. If the person making the Claim Denial is not the Medical Director but a designee, We will include the designee's credentials, board status, and State or States of current license.
- The relevant clinical rationale used to make the Claim Denial.
- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in

making the Claim Denial, We will reference the guideline in Our notice. We will either include a copy of the guideline with Our notice or We will inform You that a copy is available to You free of charge upon request.

- If clinical review criteria were relied upon in making the Claim Denial, We will inform You and Your treating Provider about the criteria. Our notice will be accompanied by the following statement: "The materials provided to You are criteria used by this Plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under the Member's Policy."
- If a Claim Denial is based on a Medical Necessity or experimental treatment or other similar exclusion or limit, We will include an explanation of the scientific or clinical judgment for the determination, applying the terms of this Policy to Your medical circumstances.

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

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 Member.
- Identification number.
- Date, type, and place of service.
- Your signature and the Provider's signature.

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.

Right of Recovery and Adjustment

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

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

Member's Cooperation

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

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or

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

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under this Plan. We reserve the right to make payments directly to You as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Subscriber's Policy), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services.

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

The coverage, rights, and benefits under this Policy are not assignable by any Member without the written consent of Anthem. This prohibition against assignment includes rights to receive payment, claim benefits under this Policy and/or law, and sue or otherwise begin legal action. Any assignment made without written consent from Anthem will be void and unenforceable.

Explanation of Benefits

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

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

Payment Owed to You at Death

Upon the death of a Member, claims will be payable in Our discretion to either the Member's estate or a beneficiary designated to Us. If the Provider is a Network Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

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

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

IF YOU ARE COVERED BY MORE THAN ONE POLICY

Insurance with Other Insurers

Benefits Deductible

When a Member is covered by two or more Health Benefit Plans, one plan will be “primary” and the other plan or plans will be “secondary.” When this Policy is primary, Anthem is responsible for processing and paying claims for Covered Benefits first. When You are covered by more than one policy and Anthem is secondary, We will be responsible for processing claims for Covered Benefits after the primary plan has issued a benefit determination for covered medical expenses. Anthem will first review the primary plan’s benefit determination and then pay or provide Covered Benefits as the secondary payor. Anthem’s benefits will be reduced by the amount paid by the primary plan, so that the total amount paid by all plans for a Covered Benefit will not exceed the amount payable under this Policy. When a member is covered under more than one expense-incurred health plan, payments made by the primary plan and payments made by the member for benefits covered under the secondary plan will be credited toward the deductible of the secondary plan, except where the secondary plan is designed to supplement the primary plan.

Coordination with Medicare

Unless federal law requires the Plan to be the primary payor, the benefits under This Plan for Members age 65 and older or Members otherwise eligible for Medicare, do not duplicate any benefit Members are entitled to under Medicare. Where Medicare is the responsible payor, all amounts for services that have been paid for by Us that should have been paid for by Medicare shall be reimbursed to Us by or on behalf of the Members.

Your Agreement and Responsibility Under This Policy

By accepting Your Policy, You agree to cooperate with Anthem to effect the terms of this Policy. You agree to provide prompt, accurate and complete information to Anthem about other health coverage and/or insurance policies or benefits You have. You agree to provide information about other coverage when necessary to carry out the terms of this Policy. If You have other health coverage that is through Anthem, You agree to terminate that coverage as of the effective date of this Policy to avoid having excess health coverage in place, which is prohibited by law. Other health coverage, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Worker’s Compensation and/or claims against liability or casualty insurance companies arising from an injury, illness, impairment or medical condition You receive, subject to limitations noted in RSA 415:6, II (4).

IF YOU HAVE A COMPLAINT OR AN APPEAL

Internal Appeal Procedure

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

Please refer to the "Prescription Drugs" section; the item titled "Prescription Drug List", for the process for submitting an exception request for drugs not on the Prescription Drug List.

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

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

- The person(s) reviewing Your Appeal will not be the same person(s) who made the initial Claim Denial or a subordinate or supervisor of the person(s) who made the initial Claim Denial,
- The person(s) reviewing Your Appeal will have appropriate medical and professional expertise and credentials to competently render a determination on Appeal,
- You have 180 days to file an Appeal, following receipt of Anthem's Claim Denial notification,
- You may submit written comments, documents, records, and other information relating to Your Appeal, without regard to whether those documents or materials were considered in making the initial Claim Denial,
- You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to or considered in making the initial Claim Denial,
- Your issue will be considered as new (de novo), as if the issue had not been reviewed before and as if no decision had been previously rendered. All information, documents, and other material submitted for the internal Appeal procedure will be considered without regard to whether the information was considered in making a Claim Denial,
- If Your Appeal of a Claim Denial is based in whole or in part on a medical judgment, reviews will be conducted by or in consultation with a healthcare professional who has appropriate training and experience in the field of medicine. Appeal determination notices will provide the titles and qualifying credentials of the person conducting the review. At Your request, the identity and qualifications of any medical or vocational expert whose advice was considered in making the initial Claim Denial (without regard to whether it was relied upon) will be provided.

Please note, in addition to the internal Appeal procedure described below, You may have the right to an External Review arranged through and overseen by the State of New Hampshire Insurance Department. For complete information about rights and restrictions, please see the "External Review" section below, and the State of New Hampshire Insurance Department's Consumer Guide to External Appeal (enclosed with Your Policy).

Who May Submit an Internal Appeal?

You or Your authorized representative may submit an internal Appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Member Service phone number on the first page of this Policy or on the back of Your Identification Card (1-855-748-1804). Exception: For Urgent Care Claim Appeals, Anthem will consider a healthcare professional with knowledge of Your condition (such as Your treating doctor) to be Your

authorized representative without requiring Your written acknowledgement of the representation, or

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

What Should be Included With an Internal Appeal?

A written Appeal must state plainly the reason(s) why You disagree with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Appeal should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information that You feel may have a bearing on the decision. Also, please include the following details with Your Appeal if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the three letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You don't agree; and
- Any bills that You have received from the Provider.

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

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

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

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

Blue View Vision Coverage Appeals

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

Blue View Vision
P. O. Box 1122
Minneapolis, MN 55440-1122

As an alternative, You may submit an internal Appeal through Anthem's website, www.anthem.com. Your Appeal must be submitted within at least 180 days of Anthem notification about the issue that caused You to Appeal.

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

- The internal Appeal is completed, or
- You seek External Review of an Adverse Determination before the internal Appeal is complete, in keeping with the terms specified in the "External Review" section.

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

Expedited Appeals. An expedited Appeal procedure is available for Urgent Care Claim Denials, or

Claim Denials concerning an admission, availability of care, continued stay or healthcare service for Members who have received Emergency Services, but who have not been discharged from a Facility. You may submit information to support Your Appeal by telephone, facsimile or other expeditious method.

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

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

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

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

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

Please note, You may be eligible for an independent External Review overseen by the State of New Hampshire Insurance Department before completing the internal Appeal process. Please see the "External Review" section for more information.

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

- The specific reason or reasons for the determination. You will be informed about any guideline (such as a policy provision, internal rule or protocol or other similar criteria) that was relied upon in making the determination. A copy of the guideline will be provided, or You will be informed that a copy is available free of charge at Your request,
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits, (the records on file with Anthem may be limited in scope. Please contact Your doctor if You have questions or concerns about the content of Your medical records),
- A statement describing all other dispute resolution options available to You, including but not limited to Your options for external review or for bringing a legal action,
- If the Claim Denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, You will receive an explanation of the scientific or clinical judgment for the denial, applying the terms of Your Policy to Your medical circumstances, or You will be informed that such explanation will be provided free of charge at Your request.
- Appeal determination notices will remind You that You have the right to contact the Insurance Commissioner's office for assistance. The Insurance Commissioner's address and toll-free telephone number will be included in Anthem's notice.

External Review

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

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

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

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

- The service under Appeal is a Covered Service and is not subject to an exclusion or annual maximum, as stated in Your Policy. Or, the service would be covered if certain clinical conditions were met and the decision about coverage is therefore an Adverse Determination. (For example, Anthem may determine that service is Experimental, Investigative or cosmetic and You disagree that the service is Experimental, Investigative or cosmetic. Another example is: Anthem may deny coverage for care outside the Network because Anthem finds that appropriate care can be provided in the Network and You disagree with the finding), and
- Your review request is not for the purpose of pursuing a claim or allegations of healthcare Provider malpractice, professional negligence or other professional fault, and
- You have completed the internal Appeal procedure stated in the "Internal Appeal Procedure" section, and the final decision is adverse, or
- the time frames stated for completion of the internal Appeal procedure are not met, or
- You and Anthem agree to submit the Appeal for External Review before the internal Appeal procedure is completed, or
- Your treating doctor certifies that Your life or health is in serious jeopardy and You cannot adhere to the regulatory time frames. Therefore, if You meet the standard for an expedited external review, You may pursue an external review simultaneously with the internal review process, even without a final Adverse Determination.

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

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

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

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

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

C. **The Insurance Department's Guide to External Review Rights.** You are encouraged to read

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

Please note. Anthem will forward to You and the IRO all the information in Anthem's possession that is relevant to Your Appeal within 10 days of receiving notice from the Insurance Department that Your request for External Review is accepted. The information may include medical records, as required by law. The records on file with Anthem may be limited in scope. Please contact Your doctor if You have questions or concerns about the content of Your medical records. The Insurance Department and IRO will not disclose protected health information or other internal materials prepared for specific External Reviews.

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

If an expedited External Review is conducted during Your Hospital stay or while You are continuing a course of treatment, Your stay or treatment will continue, as directed by Your doctor. You will be held harmless for the cost of the care under review, pending the determination of the IRO. This provision does not waive Your Cost Sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in Your Policy. If the external review results are adverse to You, You will be responsible for paying the cost of non-Covered Services beginning on the date You receive notice of the Adverse Determination.

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

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

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

Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. 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.

Limitation on Benefits of This Policy

No person or entity other than Anthem and Members are entitled to bring any action to enforce any provision of this Policy against Anthem or Members and the provisions of this Policy will be solely for the

benefit of, and enforceable only by, Anthem and the Members covered under this Policy.

Disagreement with Recommended Treatment

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

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

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

Subscriber Eligibility

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

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of New Hampshire and meet the following applicable residency requirements:

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

- Not be living in an institution;
- Be capable of indicating intent; and
- Reside in the service area applicable to this Policy.

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

- Not be living in an institution;
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Reside in the service area applicable to this Policy.

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

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

1. resides, intends to reside (including without a fixed address); or
2. is seeking employment (whether or not currently employed); or
3. has entered with a job commitment.

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

For tax households with Members in multiple Exchange service areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency requirements.

2. If both spouses in a tax household enroll in a QHP through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets residency requirements.

Dependent Eligibility

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

1. The Subscriber's legal spouse.
2. The Subscriber's domestic partner – domestic partner or domestic partnership – the definition of domestic partnership shall be two individuals, of the same sex or opposite sex, that have been each other's sole domestic partner for 12 months or more; are mentally competent; at least 18 years old; who are not related in any way (including by blood or adoption) that would prohibit marriage under State law; not married to or separated from anyone else; and are financially interdependent.

   In establishing an Effective Date of coverage all provisions of this section apply to domestic partners and their eligible children.

   a. For purposes of this Policy, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.

   b. A domestic partner's or a domestic partner's child's coverage ends at the end of the month of the date of dissolution of the domestic partnership.

   c. To apply for coverage as domestic partners, both the Subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange.
3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical impairment. These Dependents must be chiefly financially dependent on the Subscriber or Subscriber's spouse. The Dependent's impairment must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must receive proof of the Dependent's incapacity within 31 days of the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's status changes and if he or she is no longer eligible for continued coverage.

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

Temporary custody is not sufficient to establish eligibility under this Policy.Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Policy unless required by the laws of this State.

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored Plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored Plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move;
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide; and
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

If You cannot find Your situation, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in Minimum Essential Coverage at least one day in the 60 days before marriage; or lived abroad for one or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.

Newborn and Adopted Child Coverage

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

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

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

Adding a Child due to Award of Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship for a child, an application to cover the child under the Subscriber's Policy must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

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

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to Anthem.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date. Advance Payments of the Premium Tax Credit and Cost Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event;
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event; and
4. In the case of new access to an ICHRA or new provision of a QSEHRA, if the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

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

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee or Subscriber;
4. Termination of employment;
5. Reduction in the number of hours of employment;

6. Individual who no longer resides, lives or works in the Anthem's service area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA benefits.

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

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

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under: this Policy. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, changes in income, change of Dependent's impairment or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

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

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

Statements and Forms

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

WHEN MEMBERSHIP ENDS (TERMINATION)

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

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

1. The Member terminates his or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, moves outside the service area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member fails to pay his or her Premium, and the grace period has been exhausted;
4. Rescission of the Member's coverage;
5. The QHP terminates or is decertified;
6. The Member changes to another QHP;
7. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
8. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace Period" refers to either:

1. The three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; or
2. The applicable 31 day grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) 14 days after the termination is requested, if the Member does not provide reasonable notice; or
   c) On a date determined by the Member's QHP Issuer, if the Member's QHP Issuer is able to implement termination in fewer than 14 days and the Member requests an earlier termination Effective Date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the service area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, except when a Member turns age 26, the Member remains on the Policy until the end of the Plan Year, or on the date specified if the Member timely requests an earlier termination Effective Date.
4. In the case of a termination for non-payment of Premium and the three month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the three month grace period.
5. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.

7. The day following the Member's death. When a Subscriber dies, the surviving spouse or domestic partner of the deceased Subscriber, if covered under the Policy, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested Effective Date of termination.

Guaranteed Renewable

Coverage under this Policy is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Policy annually provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Policy.
3. This Policy has not been terminated by the Exchange.

Loss of Eligibility

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

Rescission

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

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

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. The validity of this Policy shall not be contested for information provided on the application, including any statements made about insurability except as permitted by law, after it has been in force for two Years from its Effective Date. However, Anthem shall not be precluded from terminating a Member based upon his or her eligibility for coverage under the Policy or upon other provisions in the Policy.

Discontinuation of Coverage

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

Grace Period

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

If the Subscriber does not pay the required Premium by the end of the grace period, the Policy is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Year, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the three month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to terminate the Policy as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three month grace period.

Subscriber Does Not Receive APTC

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

Reinstatement

If any renewal Premium is not paid within the grace period, a subsequent payment of the Premium to Anthem, or to any agent duly authorized by Anthem to receive such Premium, will reinstate the Policy. We have the right to require an application for reinstatement. All Policy provisions in place prior to the lapse in coverage will apply after reinstatement. Any Premium accepted in connection with a reinstatement shall be applied to a period for which Premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

After Termination

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

Removal of Members

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

Refund of Premium

Upon termination, We shall return promptly the unearned portion of any Premium paid. If You choose to voluntarily terminate Your membership, after its original term, please submit Your request in writing to Anthem. Your membership will be terminated effective the date We receive Your written request or at a later date as requested in writing by You. We will return any unearned portion of the Premium paid within 30 days. The earned Premium shall be computed on a pro-rata basis

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Changes in Premiums

The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 60 days prior to such change. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

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

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com
- by mail using the address on Your Premium notice
- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- pay in person at any approved retailer found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card (1-855-748-1804).

Electronic Funds Transfer

If You submit a personal check for Premiums payment, You automatically authorize Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

Administrative Fee

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

Premiums Paid by a Third Party

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

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

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

Policies, Procedures and Pilot Programs

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

Confidentiality and Release of Information

Applicable State and federal law requires Us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing Our policies and procedures regarding the protection, use and disclosure of Your medical information is available on Our website and can be furnished to You upon request by contacting Our Member Services department.

Obligations that arise under State and federal law and policies and procedures relating to privacy that are referenced but not included in this Policy are not part of the Contract between the parties and do not give rise to contractual obligations.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

Notice of Privacy Practices

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

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

Refusal to Follow Recommended Treatment

If a Member refuses treatment that has been recommended by Our Network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see

another Provider of the same specialty for a Second Opinion. The Member can also pursue the Appeal process.

Misstatement of Age

If the Premium for this Policy is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

Notice

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

Not Liable for Provider Acts or Omissions

We are not liable for the acts or omissions by any individuals or institutions furnishing care or services to You.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not prohibited by law.

Third Party Liability

These provisions apply when We pay benefits as a result of injuries or illness You sustained and You have a right to a Recovery or have received a Recovery as a result of actions or omissions of a third party. We will automatically have a lien upon any Recovery. Our lien will equal the amount of benefits We pay on Your behalf for injuries, disease, condition or loss You sustained as a result of any act or omission for which a third party is liable. Our lien will not exceed the amount We actually paid for those services.

In this section, "Recovery" means money You (or Your estate, parent, trustee or legal guardian) receive, are entitled to receive, or have a right to receive, whether by judgment, award, settlement or otherwise as a result of injury or illness caused by the third party, regardless of whether liability is contested. In this section "third party" refers to any person or entity who is legally responsible in relation to the injuries or illnesses sustained by You for which We paid benefits, including but not limited to the party(ies) who caused the injury or illness ("tortfeasor"), the tortfeasor's insurer, the tortfeasor's indemnifier, the tortfeasor's guarantor, the tortfeasor's principal or any other person or entity responsible or liable for the tortfeasor's acts or omissions, Your own insurer (underinsured or uninsured motorist benefits, medical payments, no fault benefits, personal injury protection, etc.), or any other person, entity, policy or plan that may be liable or responsible in relation to the injuries or illness, to the extent permitted by law.

We, or Our designee, have a right to file a lien and shall be entitled to payment, reimbursement and/or subrogation to the extent permitted by law.

Subrogation

- We shall be subrogated to Your rights as to any Recovery and have first priority rights to take whatever legal action necessary against any party or entity to recover Our lien.
- We may proceed in Your name against the responsible party. Additionally, We have the right to recover Our lien from any party responsible for compensating You.
- To the extent the total assets available from a Recovery are insufficient to satisfy in full Our subrogation claim and any claim still held by You, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney's fees, other expenses or costs.

- We are not responsible for any attorney's fees, other expenses or costs You incur without Our prior written consent. Further, the "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by Us.

Right of Reimbursement

- As a condition of receiving benefits in relation to this section, You acknowledge Your obligation to cooperate with Us in the recovery of Our lien amount and to provide Us with information about Your settlement, including but not limited to the amount of Your settlement.
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.
- We are not bound by, nor responsible for any fees or costs recoverable by or assigned to Your attorney as set forth in any fee agreement.

Member's Duties

- Your signed application for coverage and/or Your receipt of benefits under this Plan authorizes and/or acknowledges each of Our rights set forth in this section.
- You, or Your attorney, must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties involved.
- You agree to advise Us, directly or through Your attorney, in writing of Your claim against a third party, or a claim against Your own insurance, within 60 days of making such claim, unless a shorter period of time is prescribed by law, and that You or Your attorney will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our lien rights.
- Relevant information includes, but is not limited to, police reports, pleadings, settlement agreements, and communications with any party regarding the accident, incident, injury or illness.
- Neither You, nor Your attorney, shall take any action that may prejudice Our rights or interests under this section.
- You and/or Your attorney must cooperate with Us in the investigation, settlement and protection of Our rights.
- You and/or Your attorney must immediately notify Us if a trial is commenced, if a settlement occurs or is consummated, or if potentially dispositive motions are filed in a case.
- You and/or Your attorney must hold in trust the extent of Our lien that is recoverable by Us under the law and the Recovery must not be dissipated or disbursed until such time as We have been repaid in accordance with these provisions.
- If You, or Your attorney, fail to give Us notice, fail to cooperate with Us, or intentionally take any action that prejudices Our rights, You will be in material breach of this Agreement. In the event of such material breach, You will be personally responsible and liable for reimbursing to Us the amount of benefits We paid.

Nothing in this Plan shall be construed to limit Our right to utilize any remedy provided by law to enforce Our rights to recover Our lien.

Any action that interferes with Our right to recover Our lien may result in the termination of coverage as allowed by law for You and Your covered Dependents.

The Plan is entitled to recover any attorney's fees and costs incurred in enforcing any provision in this section.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Contract will remain in force and effect.

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.

Right to Change Plan

No agent or employee of the Plan or other person, except an authorized officer of the Plan, has authority to waive, even if by providing incomplete or incorrect information, any conditions or restrictions or to change the form or content of this Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information. Such changes can be made only through a written endorsement, signed by an officer of the Plan.

Workers' Compensation

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

Care Coordination

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

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.

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. We may also offer, at Our discretion, the ability for You to participate in certain voluntary health or condition focused digital applications or use other technology based interactive tool, or receive educational information in order to help You stay engaged and motivated, manage Your health, and assist in Your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Share. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving

certain milestones may be a feature of the program. We may discontinue an incentive or a program 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.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving healthcare. As Your healthcare partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of doctors and other healthcare professionals, who help You make the best decisions for Your health.

You have the right to:

- Speak freely and privately with Your doctors and other healthcare professionals about healthcare options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors and other healthcare professionals to make choices about Your healthcare.
- 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.
- Receive information You need to fully engage with Your health Plan, and also share Your feedback. This includes:
    - Our company and services;
    - Our network of doctors and other healthcare professionals;
    - Your rights and responsibilities;
    - The way Your health Plan works.
- Make a complaint or file an Appeal about:
    - Your health Plan and any care You receive;
    - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care You may receive in the future. This includes asking Your doctors and other healthcare professionals to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a doctor about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.
- Get help at any time, by calling the Member Services number located on the back of Your Identification Card 1-855-748-1804 or by visiting www.anthem.com.
  Or contact Your local insurance department:
  NEW HAMPSHIRE
  Phone: 1-800-852-3416
  Write: Life, Accident and Health Consumer Affairs Coordinator New Hampshire Insurance Department
  21 South Fruit Street, Suite 14, Concord, NH 03301

You have the responsibility to:

- Read all information about Your medical benefits under the Plan and ask for help if You have questions.
- Follow all medical Plan rules and policies.
- Choose a network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all healthcare professionals and staff with respect.
- Keep all scheduled appointments. Call Your doctor's office if You may be late or need to cancel.
- Understand Your health challenges as well as You can and work with Your doctors and other healthcare professionals to create an agreed upon treatment plan.
- Inform Your doctors and other healthcare professionals if You do not understand the type of care and Your actions that they are recommending.
- Follow the treatment plan that You have agreed upon with Your doctors and other healthcare professionals.
- Share the information needed with Us, Your doctors, and other healthcare professionals to help

You get the best possible care. This may include information about other health insurance benefits You have in addition to 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 www.anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID Card.

We are here to provide high-quality benefits and service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your Policy and not by this Member Rights and Responsibilities statement.

DEFINITIONS

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

Advance Payments of the Premium Tax Credit (APTC)

Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian

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

Anthem Blue Cross and Blue Shield

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

Appeal

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

Authorized Service

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

Benefit Period/Year

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

Biosimilars

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

Brand Drugs

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

Calendar Year

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

Coinsurance

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

Controlled Substances

Drugs and other substances that are considered Controlled Substances under the Controlled Substances

Act (CSA) which are divided into five schedules.

Copayment

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

Cost Share (Cost Sharing)

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

Covered Service

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the "What is Covered" section.
- Within the scope of the Provider's license;
- Rendered while coverage under this Policy is in force.;
- Not Experimental or Investigational or excluded by this policy; and
- Authorized in advance by Us if such preauthorization is required in Policy.

Deductible

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

Dependent

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

Designated Pharmacy Provider

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

Effective Date

The date when a Member's coverage begins under this Contract

Emergency Medical Condition (Emergency)

A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- placing the health of the individual or another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

1) A medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and

2) Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment to stabilize the patient.

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

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Exchange

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

Experimental/Investigative

A drug, device, medical treatment or procedure that:

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

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

Facility

A Facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Policy.

Generic/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 and that the FDA has determined meet bioequivalency standards and therefore are therapeutically equivalent. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Drug.

Habilitative Services

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

Home Delivery Pharmacy

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

Home Health Care Agency

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

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

Hospital

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

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

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

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

Identification Card/ID Card

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

Inpatient

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

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three hours per day, three 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, is expected to produce the same clinical result as the reference product in any given patient.

Maintenance Medications

A drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number listed on the first page of this Policy or on the back of Your Identification Card (1-833-201-9560) or check Our website at www.anthem.com for more details.

Maximum Allowed Amount

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

Medicaid

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

Medically Necessary or "Medical Necessity"

Healthcare services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a

manner that is:

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

When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. 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 doctor’s office or the home setting.

Please note the fact that a Network Provider or other health practitioner orders, prescribes, recommends or furnishes healthcare services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the medical director and/or independent medical specialists, peer review committees, or other healthcare professionals qualified to make a recommendation regarding the Medical Necessity of any service or product, prescribed for a Member.

You have the right to Appeal benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding Medical Necessity. Please refer to the Appeal process in “If You Have a Complaint or an Appeal” section, of this Policy for complete information.

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

Medicare

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

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Use Disorder

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage

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

Network Pharmacy

A Network Pharmacy is a Pharmacy that has a Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. Network Pharmacies may be based on a restricted network, and may be different than the network of Network Pharmacies for Our other products. To find a Network Pharmacy near You, call Pharmacy Member Services at (1-833-201-9560) the telephone number on the back of Your Identification Card.

Network Provider

Any Provider (such as, but not limited to: doctors, Specialists, healthcare professionals, healthcare practitioners or Hospitals) that has a written payment agreement with Anthem to provide Covered

Services to Members. Network doctors include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRN) acting within the scope of their licenses.

Out-of-Network Pharmacy

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

Out-of-Network Provider

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

Out-of-Network Services

A Covered Service that is not furnished by a Network Provider.

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 healthcare that Your Plan doesn't cover. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Policy. Please see the "Schedule of Cost Share and Benefits" for details.

Outpatient

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

Partial Hospitalization Program

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

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

The process to make clinically based recommendations that will help You access quality, low cost medicines within Your benefit program. The process includes healthcare professionals such as nurses, pharmacists, and doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Prescription Drug List. 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.

Anthem's PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Plan

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

Policy

The agreement, between Us and the Subscriber, which is a summary of the terms of Your benefits. It includes this Contract, Your Schedule of Cost Share and Benefits, Your application, any supplemental application or change form, Your Identification Card, and any endorsements or riders.

Precertification

A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date.

Premium

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

Prescription Drug

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

Prescription Drug List

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

Prescription Order (Prescription)

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

Primary Care Physician ("PCP")

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider

A professional or Facility licensed by law that gives healthcare services within the scope of that license and is approved by Us. This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Policy. If You have a question about a Provider not described in this Policy please call the telephone number on the back of Your Identification Card (1-855-748-1804).

Qualified Health Plan (QHP)

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer (QHP Issuer)

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

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the

Exchange in a QHP in the individual market.

Referral

A specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Provider. A recommendation from a Provider is a Referral only to the extent of the specific services approved by the PCP on the written Referral form or by other notification methods prescribed by Anthem for use by PCPs. A general statement by a PCP that a Member should seek a particular type of service or Provider does not constitute a Referral under this Booklet.

Rehabilitative Services

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

Residential Treatment Center/Facility:

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

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more doctors available at all times.
3. Residential treatment that takes place in a structured Facility-based setting, and does not take place outdoors, e.g., wilderness program or therapy.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. A Facility that is designated residential, subacute or intermediate care and may occur in care systems that provide multiple levels of care.

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial care
6. Educational care
7. Wilderness therapy or programs

Retail Pharmacy

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

Self-Administered Drugs

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

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. 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; or a place for rest, educational, or similar services.

Specialty Care Physician (Specialist or SCP)

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 healthcare.

Specialty Drugs

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

Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

Each of the 50 States and the District of Columbia.

Subscriber

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

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at a Network Facility; and
- Out-of-Network air ambulance services.

Tax Dependent

Has the same meaning as the term Dependent under the Internal Revenue Code.

Tax Filer

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

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

Urgent Care

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

Urgent Care Center

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

Utilization Review

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

We, Us and Our

Anthem Blue Cross and Blue Shield

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

Anthem

Individual Major Medical Expense Coverage

Outline of Coverage

Read Your Policy Carefully – This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, Inpatient Hospital medical services, and Outpatient Hospital services, subject to any Deductibles, Copayment and Coinsurance provisions, or other limitations that may be set forth in the Policy. Basic Hospital or basic medical insurance coverage is not provided.

Covered Services	**Benefits** Please see Your Schedule of Cost Share and Benefits for Your Copayment, Deductible and Coinsurance.
Daily Hospital Room and Board (semi-private room rate)	You pay the Copayment (if applicable) Deductible and Coinsurance shown on Your Schedule of Cost Shares and Benefits.
Miscellaneous Hospital Services Emergency Room Charge	You pay the Emergency Copayment and any Deductible and Coinsurance shown on Your Schedule of Cost Shares and Benefits.
Surgical Services Anesthesia Services Inpatient - Hospital Medical Services	You pay the Deductible and Coinsurance shown on Your Schedule of Cost Shares and Benefits.
Outpatient - Hospital Medical Services Office Visits	You pay the visit Copayment (if applicable) and any Deductible and Coinsurance shown on Your Schedule of Cost Shares and Benefits.
Other Benefits Durable Medical Equipment Ambulance	You pay the Deductible and Coinsurance shown on Your Schedule of Cost Shares and Benefits.

What Is Not Covered (Exclusions)

In this section You will find a review of items that are not covered by Your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary.

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.

The following services are not covered:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital.
- Services by Out-of-Network Providers unless:
  - the services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
  - the services are approved in advance by Anthem.

Medical Services

Your medical benefits do not cover:

Abortions. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed.

Affiliated Providers. Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

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

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

Allergy Tests/Treatment. The following services, supplies or care are not covered:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Antigen leukocyte cellular antibody test (ALCAT).
- Cytotoxic test.
- HEMOCODE Food Tolerance System.
- IgG food sensitivity test.
- Immuno Blood Print test.
- Leukocyte histamine release test (LHRT).

Alternative/Complementary Medicine. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial

synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance. Usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or doctor is not a Covered Service. Non Covered Services for ambulance include but are not limited to, trips to:

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

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described as a Covered Service in this Policy, unless otherwise required by law.

Armed Forces/War. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

Autopsies and Post-mortem Testing.

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 Policy.

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

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims.

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

- Any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-investigational treatments; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Complications of Non-Covered Services. Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. 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.

Compound Drugs. Unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Compound Drug to be considered Medically Necessary, the doctor must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Compound Drug is more medically beneficial than the clinically equivalent alternative.

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

Cosmetic Services. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for social reasons. No

benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded Plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

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

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

Custodial Care. Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces except as specified as a Covered Service in this Policy.

Dental Implants. For Dental implants except as specified as a Covered Service in this Policy.

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

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

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

- Transplant preparation.
- Initiation of an immunosuppressive.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

Doctor or Other Practitioners' Charges. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- For membership, administrative, or access fees charged by doctors or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

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

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

Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity

prescribed, or for any refill given more than one Year after the date of the original Prescription Order.

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

Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by State law, but not by federal law, except for injectable insulin). This exclusion does not apply to over-the-counter drugs that We must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.

Durable Medical Equipment. Covered Services do not include durable medical equipment except as specified as a Covered Service in this Policy. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specified as a Covered Service in this Policy.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

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

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

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

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

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Policy.

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

Gynecomastia. For surgical treatment of gynecomastia.

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

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements except as specified as a Covered Service in this Policy or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning,

drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

Impotency. For services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

Incarceration. For care required while incarcerated in a federal, State or local penal institution or required while in custody of federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility Testing and Treatment. Infertility testing, treatment or procedures not specifically listed in this Policy. Benefits do not include coverage for artificial insemination (AI) services or assisted reproductive technologies (ART) services or the diagnostic tests and Drugs to support AI or ART services. Examples of ART include in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

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

Maintenance Therapy. For maintenance therapy which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement. This exclusion does not apply to “Habilitative Services” in the “What is Covered” section.

Manipulation Therapy – Home. For Manipulation Therapy services rendered in the home except as specified as a Covered Service in this Policy.

Medical Chats Not Provided Through Our Mobile App. Texting or chat services provided through a service other than Our mobile app, website, or Anthem enabled devices.

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

Medicare Benefits. (1) for which benefits are payable under Medicare Parts A, B and/or D, unless prohibited by law. (2) for services or supplies provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

Missed/Cancelled Appointments. For missed or cancelled appointments.

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

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

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified as a Covered Service in this Policy. This includes, but is not limited to, suture removal in an Emergency room.

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

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified as a Covered Service in this Policy or as required by law. This exclusion includes, but is not limited to,

those nutritional formulas and dietary supplements that can be purchased over-the-counter, which by law do not require either the written Prescription or dispensing by a licensed pharmacist.

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

Outdoor Treatment Camps and/or Programs and/or Wilderness Programs.

Over-the-Counter. For drugs, devices, products, or supplies with over-the-counter equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter drug, device, product, or supply, except as specified as a Covered Service in this Policy or as required by law.

Personal Care, Convenience and Mobile/Wearable Devices. For personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a doctor. This exclusion also applies to health spas or similar Facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar Facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly (flat-head syndrome);
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Physician Stand-by Charges. For stand-by charges of a physician defined as professional physician services requested by another physician and generally involve prolonged physician attendance without direct (face to face) contact with the patient.

Private Duty Nursing. We do not provide benefits for services or charges for Private Duty Nursing.

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

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

Reconstructive Services. Reconstructive services except as specified as a Covered Service in this Policy, or as required by law.

Regression Prevention. For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable, except as specified as a Covered Service in this Policy.

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.

Reversal of Sterilization. We do not provide benefits for services to reverse sterilizations for men or women.

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

Scalp Hair Prostheses (wigs) are not covered for temporary hair loss, except as specified as a Covered Service in this Policy, or for male pattern baldness.

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as Specified as a Covered Service in this Policy.

Services Not Appropriate for Virtual Visits. Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

Services Not Listed As Covered. Benefits are not provided for any service, procedure, or supply not listed as a Covered Service in this Policy.

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

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

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

Teeth - Congenital Anomaly. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as specified as a Covered Service in this Policy or as required by law.

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

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

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

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

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

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

Virtual Visits. Virtual Visits do not include the use of facsimile, texting (outside of Our mobile app) electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside Our network, benefit Precertification or Provider to Provider discussions except as approved under the "What Is Covered" section.

Vision Orthoptic Training. For orthoptics or vision training and any associated supplemental testing.

Weight Loss Programs. For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Policy. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

Guaranteed Renewable

Coverage under this Policy is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Policy annually provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met.
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Policy.
3. This Policy has not been terminated by the Exchange.

Changes in Premiums

The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 60 days prior to such change. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Any significant misrepresentation or omission may cause Anthem to change Your Premium retroactive to

the Effective Date of coverage. If the age of the Subscriber has been misstated, all amounts payable under this Policy shall be such as the Premium paid would have been if purchased at the correct age.

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

Get help in your language

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

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

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

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

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

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíilnih. (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.