INDIVIDUAL CONTRACT

(Herein called the "Contract")

Anthem Bronze Preferred/Broad Standard ($0 Virtual PCP + $0 Select Drugs + Incentives)

Compcare Health Services Insurance Corporation
Blue Cross Blue Shield of Wisconsin

N17 W24340 Riverwood Drive
Pewaukee, WI 53188

Important Notice Regarding Payment of Covered Services

Your health insurance Plan limits benefits for Covered Services to the Maximum Allowed Amount. This amount may be less than what Your Provider bills for the service. Please see the "How Your Claims Are Paid" section for more details.

RIGHT TO EXAMINE

If this Contract is provided to You as a new Subscriber and You are not satisfied with this Contract for any reason You may, within 10 days after You receive it or have access to it electronically, whichever is earlier, return it for a full refund of the Premium paid.

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR CONTRACT

Please re-read the copy of the application You kept for Your records. Omissions or misstatements in the application may cause an otherwise valid claim to be denied. The application is part of the Contract. The Contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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 Contract to give a clear description of Your benefits, as well as Our rules and procedures.

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

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

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

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

Paul Nobile, President

How to Obtain Language Assistance

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

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

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

Contact Us

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

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

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

Anthem Blue Cross and Blue Shield
Member Services
P.O. Box 105187
Atlanta GA 30348-5187

Visit Us on-line
www.anthem.com

Home Office Address
N17 W24340
Riverwood Drive
Pewaukee, WI 53188

Hours of Operation
Monday - Friday
7:00 a.m. to 4:00 p.m. Central Time

Conformity with Law

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

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this Contract constitutes a Contract solely between Subscriber, and Compcare Health Services Insurance Corporation and Blue Cross Blue Shield of Wisconsin, each of whom do business as Anthem Blue Cross and Blue Shield (Anthem), which are independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use the Blue Cross and/or Blue Shield Service Marks in a portion of the State of Wisconsin, and that Anthem is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to Subscriber for any of Anthem's obligations to Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this Contract.

Delivery of Documents

We will provide an Identification Card and Contract 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 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 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 as 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 Non-Network Providers;
- Covered Services provided by a Non-Network Provider at a Network Facility; and
- Non-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 Non-Network.

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

Note that if You receive Emergency Services from a Non-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, Non-Network Cost Shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to Your claim if the treating Non-Network Provider determines You are stable, meaning You have been provided necessary Emergency Services such that Your condition will not materially worsen and the Non-Network Provider determines: (i) that You are able to travel to a Network Facility by nonemergency transport; (ii) the Non-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent. If You continue to receive services from the Non-Network Provider after You are stabilized, You will be responsible for the Non-Network Cost Shares, and the Non-Network Provider will also be able to charge You any difference between the Maximum Allowable Amount and the Non-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by a Non- Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Non-Network Services Provided at a Network Facility

When You receive Covered Services from a Non-Network Provider at a Network Facility, Your claims will be paid at the Non-Network benefit level if the Non-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for Non-Network Cost Shares for those services and the Non-Network Provider can also charge You any difference between the Maximum Allowable Amount and the Non-Network Provider's billed charges. 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; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

1) By obtaining Your written consent no 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 a Non-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 a Non-Network Provider for either Emergency Services or for Covered Services provided by a

Non-Network Provider at a Network Facility will be applied to Your Network Out-of-Pocket Limit.

Appeals

If You receive Emergency Services from a Non-Network Provider, Covered Services from a Non-Network Provider at a Network Facility, or Non-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 is required to confirm the list of Network Providers in its Provider Directory every 90 days. If You can show that You received 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 Non-Network rates.

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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 by Providers located outside of Wisconsin will only be Covered Services if:

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

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 Contract will allow for a Covered Service.

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

- 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 a Non-Network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	Network Member Pays	Non-Network Member Pays
Individual	$7,500	$15,000
Family	$15,000	$30,000
The Network and Non-Network Deductibles are separate and amounts applied to one, do not apply to the other. 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	Non-Network Member Pays
Coinsurance Percentage Unless specified otherwise below	50% Coinsurance	50% Coinsurance

Out-of-Pocket Limit	Network Member Pays	Non-Network Member Pays
Individual	$9,200	$30,000
Family	$18,400	$60,000
The Network and Non-Network Out-of-Pocket Limits are separate and amounts applied to one, do not apply to the other. The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more 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	Non-Network Member Pays
Ambulance Services		
Emergency	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Nonemergency Benefits for nonemergency ambulance services will be limited to $50,000 per trip if a Non-Network Provider is used. Except, for air ambulance services, You will be responsible for amounts over the Maximum Allowed Amount.	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Autism Services	Cost Share determined by place of service and the Covered Service received	$0 Copayment 50% Coinsurance
Dental Services When provided for accidental injury or for certain Members requiring general anesthesia Limited to a maximum of $3,000 per Member, per dental accident, and $900 per tooth	Cost Share determined by place of service and the Covered Service received	$0 Copayment 50% Coinsurance
Diabetes Services Includes supplies, equipment and education	Cost Share determined by place of service and the Covered Service received	$0 Copayment 50% Coinsurance
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Advanced Imaging Services	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Doctor (Physician) Visits		
Office Visits with: • Primary Care Physician (PCP) • Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic • Chiropractor	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Virtual Visits with PCP	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Virtual Visits from PCP Virtual Care-Only Provider through Our mobile app and website	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	Deductible does not apply; $100 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Mental Health and Substance Abuse Provider (including in-person and/or Virtual Visits)	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Other Office Services	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Emergency Room Visits Additional Cost Share determined based on service received	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Home Care Services Limited to a maximum of 60 visits per Member, per Calendar Year	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Hospice Care	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance

Medical Services	Network Member Pays	Non-Network Member Pays
Hospital Services		
Inpatient Facility	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Outpatient Facility	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Inpatient and Outpatient Professional Services	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Medical Supplies, Durable Medical Equipment and Appliances Limited to a single purchase of a type of DME/Prosthetic, including repair and replacement, every three Years **Hearing Aids** Limited to one hearing aid per Member, per ear, every three Years **Bone Anchored Hearing Aids/Cochlear Implants** If You meet the criteria for a bone anchored hearing aid or cochlear implant, coverage is provided for one hearing aid or cochlear implant per ear during the entire period of time that You are enrolled under this Contract. Replacements and/or repairs for a bone anchored hearing aid are covered only for malfunctions. See “What is Covered” section for criteria **Prosthetics** Limited to a single purchase including repair, fitting and replacement components every three Years	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Physical Medicine and Rehabilitation		

Medical Services	Network Member Pays	Non-Network Member Pays
Inpatient Facility	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Outpatient Facility	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Inpatient and Outpatient Professional Services Limited to a maximum of 60 days per Member, per Calendar Year **Note:** For Outpatient therapy limits, see the "Therapy Services – Outpatient" section	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Preventive Care Services Network services required by law are not subject to Deductible Services include lead poisoning screening for Dependents under age six, as required by State law Additional Cost Share determined based on service received	Deductible does not apply; $0 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Skilled Nursing Facility Limited to a maximum of 30 days per Member, per admission	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Surgery **Ambulatory Surgical Center**	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Therapy Services – Outpatient Includes coverage for Chemotherapy, Occupational, Physical, Radiation, Respiratory and Speech Therapies 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). The limits do not apply to Mental Health and Substance Abuse conditions		

Medical Services	Network Member Pays	Non-Network Member Pays
Cardiac Rehabilitation Limited to a maximum of 36 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Occupational Therapy Limited to a maximum of 20 visits per Member, per Calendar Year		
Office Visit	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Outpatient Facility	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Physical Therapy Limited to a maximum of 20 visits per Member, per Calendar Year		
Office Visit	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Outpatient Facility	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Pulmonary Rehabilitation Limited to a maximum of 20 visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of Physical Therapy, the Physical Therapy limit will apply instead of the limit listed here	$0 Copayment 50% Coinsurance	$0 Copayment 50% Coinsurance
Speech Therapy Limited to a maximum of 20 visits per Member, per Calendar Year		

Medical Services	Network Member Pays	Non-Network Member Pays
Office Visit	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Outpatient Facility	Deductible does not apply; $50 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Transplant Human Organ and Bone Marrow/Stem Cell/Cord Blood **Transplant Transportation and Lodging** Network only $10,000 maximum benefit limit per transplant **Unrelated Donor Search** 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	$0 Copayment 50% Coinsurance
Urgent Care Center Additional Cost Share determined based on service received	Deductible does not apply; $75 Copayment per Urgent Care visit 0% Coinsurance	Deductible does not apply; $75 Copayment per Urgent Care visit 0% Coinsurance

Prescription Drugs

Retail Pharmacy Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 1	Deductible does not apply; $25.00 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Tier 2	$50.00 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Tier 3	$100.00 Copayment 0% Coinsurance	$0 Copayment 50% Coinsurance
Tier 4	$500.00 Copayment 0% Coinsurance	Not Covered

Notes:

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

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).

We may increase the Cost Shares listed above in order to take full advantage of Cost Share assistance that is available from drug manufacturers. This will lower Plan costs but will not increase Your cost because any additional Cost Share will be offset by the Cost Share assistance.

Home Delivery Prescription Drugs	Network Member Pays	Non-Network Member Pays
Tier 1 (90-day supply)	Deductible does not apply; $62.50 Copayment 0% Coinsurance	Not Covered
Tier 2 (90-day supply)	$150.00 Copayment 0% Coinsurance	Not Covered
Tier 3 (90-day supply)	$300.00 Copayment 0% Coinsurance	Not Covered
Tier 4 (30-day supply)	$500.00 Copayment 0% Coinsurance	Not Covered

Home Delivery Prescription Drugs	Network Member Pays	Non-Network Member Pays
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). We may increase the Cost Shares listed above in order to take full advantage of Cost Share assistance that is available from drug manufacturers. This will lower Plan costs but will not increase Your cost because any additional Cost Share will be offset by the Cost Share assistance.		
Orally-Administered Cancer Chemotherapy	As required by Wisconsin law, You will not have to pay a Cost Share (Deductible or Coinsurance) for the orally-administered chemotherapy You get at a Retail or Home Delivery Pharmacy that is higher than the Cost Share You pay for intravenously-administered or injected chemotherapy covered under the "Prescription Drugs Administered by a Medical Provider" benefit.	

Pediatric Dental Services

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

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

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

Pediatric Dental Care	Network Member Pays	Non-Network Member Pays
Diagnostic and Preventive Services	0% Coinsurance	30% Coinsurance
Basic Restorative Services	40% Coinsurance	50% Coinsurance
Oral Surgery Services	50% Coinsurance	50% Coinsurance
Endodontic Services	50% Coinsurance	50% Coinsurance
Periodontal Services	50% Coinsurance	50% Coinsurance
Major Restorative Services	50% Coinsurance	50% Coinsurance
Prosthodontic Services	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Care Services	50% Coinsurance	50% Coinsurance

Pediatric Vision 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	Non-Network Member Pays
Routine Eye Exam Covered once per Calendar Year per Member	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Standard Plastic Lenses One set of lenses covered per Calendar Year per Member.		
Single Vision	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Bifocal	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Trifocal	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Progressive	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Lenticular	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Additional Lens Options Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from Network Providers.		
Frames (formulary) One frame covered per Calendar Year per Member.	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per Calendar Year per Member.		
Elective (conventional and disposable)	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount

Covered Vision Services	Network Member Pays	Non-Network Member Pays
Non-Elective	$0 Copayment	$0 Copayment up to the Maximum Allowed Amount
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.		
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 and Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year per Member.	$0 Copayment	Not Covered

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 Plan. It provides details about Network Providers who have entered into an agreement with Anthem and Non-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 POS Plan. The Plan has two sets of benefits: Network and Non-Network. If You choose a Network Provider, You will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If You use a Non-Network Provider, You will have to pay more out-of-pocket costs unless 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

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service. We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You may Appeal this decision. See the "If You Have a Complaint or an Appeal" section of this Contract.

Network Providers include Primary Care Physicians (PCPs), Specialists (Specialty Care Physicians - SCPs), other professional Providers, Hospitals, and other Facilities who contract with Us to care 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.

A consultation with a Network healthcare Provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

For services rendered by Network Providers:

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

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

If You receive Covered Services from a Non-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.

Non-Network Services

When You do not use a Network Provider, Covered Services are covered at the Non-Network level, unless 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.

For services from a Non-Network Provider:

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

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

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 or website. 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. Member Services can help You determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- 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. PCPs may provide care in person or virtually. 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 virtual care-only 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, contact 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 meet with Your PCP, be sure to have Your Member Identification Card available.

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.

Dental Providers

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

Please call Our Member Services department at 800-627-0004 for help in finding a Network dentist or visit Our website at www.anthem.com. Please refer to Your ID Card for the name of the dental program that Network Providers have agreed to service when You are choosing a Network dentist.

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 chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
2) An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits);
3) An ongoing course of treatment for pregnancy through the postpartum period;
4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery;
5) 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 Abuse Disorders; or
6) Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and are receiving treatment for such illness from such Provider or Facility.

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 Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

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 Contract.

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, Non-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 Contract includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Contract. 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 lower level place of care or lower cost setting, will not be Medically Necessary if they are given in a higher level place of care, or higher cost setting. This means that a request for a service may be denied because it is not Medically Necessary for that service to be provided in the place of care or setting that 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 type of 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.

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

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

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

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

Types of Reviews

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

      For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us 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.

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

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage determination 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.
Non-Network	Member	• 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® Provider	Member **(Except for Inpatient admissions)**	• 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 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.

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

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision and Notification
Urgent pre-service Review	72 hours from the receipt of the request
Non-Urgent pre-service Review	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
Urgent Concurrent/Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent/Continued Stay Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Concurrent/Continued Stay Review	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

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

Important Information

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 cost effective, value based and/or quality services.

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

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

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

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical Utilization 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 Plan. We will make Our decisions case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

WHAT IS COVERED

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

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

- “Schedule of Cost 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 pre-authorization
- “What Is Not Covered (Exclusions)” – for details on services that are not covered

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

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

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are 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 a Non-Network Hospital to a Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

Non-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount except for Surprise Billing Claims.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, must be preauthorized.

Air and Water Ambulance

Air and water ambulance services are subject to Medical Necessity review by Us. We retain the right to select the air ambulance Provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for nonemergency Hospital to Hospital transports must be preauthorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Services

Your Contract covers the treatment of autism spectrum disorders. The following definitions apply to this section only:

- Autism spectrum disorder – any of the following: (1) autism disorder; (2) asperger's syndrome; or

(3) pervasive developmental disorder not otherwise specified.

- Behavioral – interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning used to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.
- Department – Wisconsin Department of Health Services.
- Evidence-based – therapy that is based upon medical and scientific evidence and is determined to be an efficacious treatment or strategy.
- Efficacious treatment or efficacious strategy – treatment or strategies designed to address cognitive, social or behavioral conditions associated with autism spectrum disorders; to sustain and maximize gains made during intensive level services; or to improve the condition of a Member with autism spectrum disorder.
- Intensive level services – Evidenced-based behavioral therapies that are directly based on, and related to, a Member's therapeutic goals and skills as prescribed by a doctor familiar with the Member.
- Non-intensive level services – evidence-based therapy that occurs after the completion intensive level services that is designed to sustain and maximize gains made during treatment with intensive level services. It also includes evidence-based therapy for a Member who has not and will not receive intensive level services, but for whom non-intensive level services will improve the Member's condition.
- Provider – a State-licensed psychiatrist, Psychologist, or a social worker certified or licensed to practice psychotherapy. It includes a behavior analyst who has been licensed by the State of Wisconsin and has been certified by the Behavior Analyst Certification Board, Inc.
- Qualified paraprofessional – an individual working under the active supervision of, and received regularly scheduled oversight by, a qualified supervising Provider and who is at least 18 years of age and has completed certain training requirements, as specified in Ins 3.36, Wis. Admin. Code.
- Qualified professional – an individual working under the supervision of an Outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and, to the extent they provide intensive level services, has completed the training requirements specified in Ins 3.36, Wis. Admin. Code.
- Qualified Provider – a Provider acting within the scope of a currently valid State-issued license to practice psychotherapy. If the Provider provides intensive level services, the Provider must also satisfy the training requirements specified in Ins 3.36, Wis. Admin. Code.
- Qualified supervising Provider – a qualified Provider that has completed at least 4,160 hours of experience as a supervisor of less experienced Providers, professionals and paraprofessionals.
- Therapy – services, treatments and strategies prescribed by a treating doctor and given by a qualified Provider to improve the Member's condition or to achieve social, cognitive, communicative, self-care or behavioral goals that are clearly defined within the Member's treatment plan.
- Therapist – a State-licensed speech-language pathologist or occupational therapist acting within the scope of their currently valid license and who gives evidence-based services.
- Waiver program means services given by the Department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

Benefits for the Treatment of Autism Spectrum Disorders

Benefits are available for the services below for Members with a verified diagnosis of autism spectrum disorder. Benefits include intensive level services given by a therapist. We may require You to get a second opinion to verify the diagnosis.

Intensive Level Services. Covered Services include intensive level services, the majority of which shall be given to the Member when the parent or legal guardian is present and engaged. Intensive level services must meet all of the following:

- Be based upon a treatment plan developed by a qualified Provider that includes at least 20 hours per week over a 6-month period of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of

autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention. We may ask for and review the Member's treatment plan and the summary of progress on a periodic basis;
- Given by qualified Providers, qualified supervising Providers, qualified professionals, therapists or qualified paraprofessionals;
- Given in an environment most conducive to achieving the goals of the Member's treatment plan;
- Include training and consultation, team meetings and active involvement of the Member's family to implement the therapeutic goals developed by the team;
- Begin after a Member is two years of age and before the Member is nine years of age; and
- Include that the Member is directly observed by the qualified Provider at least once every two months.

Non-Intensive Level Services. Benefits for non-intensive level therapy services that are evidenced-based and given to a Member by a qualified Provider, qualified professional, therapist or qualified paraprofessional are covered in either of the following situations:

- After intensive level services are completed, when services are designed to sustain and maximize gains made during intensive level services; or
- To a Member who has not and will not get intensive level services but for whom non-intensive level services will improve their condition.

Non-intensive level services must meet all of the following:

- Be based on a treatment plan developed by a qualified Provider, qualified supervising Provider, qualified professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Member be present and engaged in the intervention. We may ask for and review the Member's treatment plan and the summary of progress on a periodic basis;
- Given by qualified Providers, qualified supervising Providers, qualified professionals, therapists or qualified paraprofessionals;
- Given in an environment most conducive to achieving the goals of the Member's treatment plan;
- Include training and consultation, team meetings and active involvement of the Member's family to implement the therapeutic goals developed by the team;
- Include supervision of qualified Providers, qualified professionals, therapists and qualified paraprofessionals by qualified supervising Providers on the treatment team.

Change from Intensive Level Services to Non-Intensive Level Services. We will give a Member, or his/her authorized representative, notice of the change in a Member's level of treatment. The notice will state the reason for the change and may include any of the following:

- The Member has received four cumulative Years of intensive level services;
- The Member no longer needs intensive level services as supported by documentation from a qualified Provider or qualified supervising Provider; or
- The Member no longer gets evidence-based therapy for at least 20 hours per week over a 6-month period of time.

The Member, or his/her representative, should contact Us if he/she is unable to get intensive level services for an extended period of time. They must tell Us the specific reason(s) why the Member or the Member's family or care giver is unable to comply with an intensive level service treatment plan. Reasons for asking for an interruption in intensive level services for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason acceptable to Us. We will not deny intensive level services to a Member for failing to maintain at least 20 hours per week of evidence-based behavioral therapy over a 6-month period when:

- The Member contacts Us as stated above; or
- The Member, or his/her authorized representative, can document that the Member was unable to maintain at least 20 hours per week of evidence-based behavioral therapy due to waiting for waiver program services.

Note: The benefits in this section do not include benefits for durable medical equipment and Prescription

Drugs. Please refer to the rest of this Contract for details on those benefits.

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 Contract. 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; cardiovascular disease (cardiac/stroke); surgical musculoskeletal disorders of spine, hip and knees; and other diseases or disorders that We determine qualify as an approved clinical trial. 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

Accident Related Dental Services

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

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

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

Other Dental Services

Medically Necessary Hospital or ambulatory surgical Facility charges and anesthetics provided for dental care are covered if the Member meets any of the following conditions:

- The Member is age 19 or younger;
- The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes Services

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

Diabetes self-management training is covered for an individual with insulin dependent diabetes, noninsulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a doctor or a podiatrist; and
- Provided by a healthcare professional who is licensed, registered, or certified under State law.

For the purposes of this benefit, a "healthcare professional" means the doctor or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

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

Diagnostic Services Outpatient

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

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology
- PET scans
- PET/CT fusion scans
- QCT bone densitometry
- Diagnostic CT colonography

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

Doctor (Physician) Visits

Covered Services include:

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

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 virtual care-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 or website; interactive store and forward (asynchronous) 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.

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.

Kidney Disease Treatment for kidney disease treatment including dialysis, transplantation, and donor-

related services. For details specific to transplantation and donor-related services see the “Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood” subsection.

Members with end stage renal disease (ESRD) should contact Medicare about enrollment and benefit options.

Nurse Practitioner Services for papanicolaou tests (pap smears), pelvic examinations, and associated diagnostic services provided by a licensed nurse practitioner if benefits are available for the services when provided by a doctor. The nurse practitioner must be practicing within the scope of his or her license in order for benefits to be 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 or independent freestanding Emergency department 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 or independent freestanding Emergency department 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, regardless of the department of the Hospital in which such further examination or treatment is furnished, 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 as soon as possible. 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 a Non-Network Provider, Covered Services will be covered at the Non-Network level 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. Home care visit limits specified in the “Schedule of Cost Share and Benefits” for home care services apply when therapy services are rendered in the home.

Benefits may also be available for Inpatient Hospital Care in Your home. These benefits are separate from the Home Care Services benefit and are described in the “Inpatient Hospital Care” section below.

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 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 Contract.

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.

When available in Your area, certain Providers have programs available that may allow You to receive Inpatient services in Your home instead of staying in a Hospital. To be eligible, Your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under "Home Care Services." Your Provider will contact You if You are eligible, and provide You with details on how to enroll. If You choose to participate, the Cost Shares listed in Your "Schedule of Cost Share and Benefits" under "Hospital Services" will apply.

Inpatient Professional Services

Covered Services include:

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

Outpatient Hospital Care

Your Plan includes Covered Services in an:

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

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

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

- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Maternity and Reproductive Health Services

Maternity Services

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

Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent
- Prenatal, postnatal, and postpartum services
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us

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

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

Contraceptive Benefits

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

Sterilization Services

Benefits for men and women include sterilization services. Reversals of sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care Services" benefit.

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 – Any wearable, nondisposable instrument or device designed to aid or compensate for impaired human hearing.
- Cochlear implants – A surgically implanted device that allows hearing.
- Bone anchored hearing aids – benefits are available only if You have either of the following:
    - Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
    - Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
    - Replacements and/or repairs for a bone anchored hearing aid are covered only for malfunctions.

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).

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 (one insulin pump per year, glucose monitor, lancets and test strips, etc).

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Mental Health and Substance Abuse Services

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

Covered Services include the following:

- Inpatient Services in a Joint Commission accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Outpatient Services including in-home and office visits and treatment in an Outpatient department of a Hospital or Joint Commission or CARF-accredited Outpatient Facility, such as Partial Hospitalization Programs and Intensive Outpatient Programs.
- Virtual Visits as described under “Doctor (Physician) Visits” subsection.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by The Joint Commission or CARF. It 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,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C.) or
- Any agency licensed by the State to give these services, when We have to cover them by law.

Transitional care is covered in the following settings:

- A certified adult mental health day treatment program as defined in HFS 61.75 Wis. Adm. Code.
- A certified child/adolescent mental health day treatment program as defined in HFS 40.04 Wis. Adm. Code.
- A certified AODA day treatment program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.
- A certified community support program as defined in HFS 63.03 Wis. Adm. Code.
- A certified residential AODA treatment program as defined in HFS 75.14(1) and (2) Wis. Adm. Code.
- Intensive Outpatient Programs for the treatment of substance abuse disorders provided in accordance with the criteria established by the American Society of Addiction Medicine.
- Services provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other Providers for stabilization.

Covered Services also include the following:

Dependent Student Benefit

A dependent student going to school in Wisconsin may get benefits for Outpatient Covered Services while they are outside the Service Area, as described below. As used in this section:

- "Dependent student" means a Dependent child enrolled in a school in Wisconsin.
- "School" means a vocational, technical, or adult education school; a center or school within the University of Wisconsin system; and any school of higher education that gives a bachelor's or higher degree.

The dependent student may get an initial assessment and, if Outpatient services are recommended, benefits for Covered Services from an Outpatient treatment Facility or other Provider in Wisconsin that is reasonably close to the school where the dependent student is enrolled. We may choose the Provider.

Benefits will not be covered if the treatment would prevent the dependent student from going to the school on a regular basis. Benefits will also not be covered if the dependent student ends his or her enrollment in the school.

Court-Ordered Services

Benefits include behavioral health and substance abuse treatment given as part of an Emergency detention, an involuntary commitment, or a court order if the services are Covered Services under this Contract.

If Covered Services are given by a Non-Network Provider, We will cover benefits at the Network Level if:

- Services could not have been given by a Network Provider; and
- The Provider, Member, or other person on behalf of the Member, contacts Us within 72 hours of getting the service.

We will then arrange for further Medically Necessary services to be given by a Network Provider, if You wish to get Network benefits. You may continue to use Non-Network Providers, but Covered Services from a Non-Network Provider will be paid at the Non-Network level. Reimbursement for services from a Non-Network Provider will be no more than the maximum reimbursement for services under the State medical assistance program.

Physical Medicine and Rehabilitation Services

Physical medicine and Rehabilitation Services are a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or Psychologist.

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

Preventive Care Services

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    - Breast cancer,
    - Cervical cancer,
    - High blood pressure,
    - Type 2 diabetes mellitus,
    - Cholesterol,
    - Child or adult obesity,
    - Colorectal cancer.
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. Covered Services also include lead poisoning screening for Dependents under age six, as required by State law.
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - Contraceptive coverage includes Generic 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. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at a $0 Cost Sharing when You receive it from a Network Provider. If Your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is necessary because a Generic therapeutic equivalent drug is not appropriate for You, You may obtain coverage of the Brand Drug with a $0 Cost Sharing if Your Provider submits an exception request to receive prior approval. Your doctor must complete a contraceptive exception form and return it to Us. You or Your doctor can find the form online at www.anthem.com or by calling the number listed on the back of Your ID Card. If Medical Necessity has been determined by Your Provider, an exception will be granted and coverage of the drug will be provided at $0 Cost Sharing. 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".

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per Calendar Year or as required by law.
- Gestational diabetes screening.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   - Counseling
   - Prescription Drugs 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 for more details about these services or view the federal government's web sites:

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

Rehabilitative Services

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.

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:

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services Outpatient

Physical Medicine Therapy Services

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

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

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy –** Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy –** Nursing, durable medical equipment and drug services that are delivered and administered to You through an I.V. Also includes total parenteral nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers Prescription Drugs when they are administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation –** Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy –** Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy –** Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **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.
- **Manipulation Therapy** includes osteopathic/chiropractic manipulation therapy used for treating problems associated with bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Please also see the "Chiropractic Services" bullet above.

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

This section describes benefits for certain covered transplant procedures that You get during the transplant benefit period. Any Covered Services related to a covered transplant procedure, received before or after the transplant benefit period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

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 a Non-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 back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the covered transplant procedure, You or Your Provider must call Our transplant department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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 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. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

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

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a

Designated Pharmacy Provider program.

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

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

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

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

Therapeutic Equivalents

Therapeutic Equivalents is a 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 equivalent is right for You. For questions or issues about therapeutic drug equivalents, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

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.

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 or check Our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

If prior authorization is denied, You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Contract.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the 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 Services" benefit. Please see that section for more details;
- Flu shots (including administration).

Benefits are also available for any Prescription Drug approved by the FDA to treat HIV infection or HIV-related illness. This includes new drugs that are in, or have finished, a phase three clinical investigation. It also includes drugs prescribed and given to You as part of an approved FDA treatment protocol.

Where You Can Get Prescription Drugs

Network Pharmacy

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

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

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single 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 Contract.

Non-Network Pharmacy

You may also use a Pharmacy that is not in Our network. You will be charged the full retail price of the drug and You will have to send Your claim for the drug to Us. (Non-Network Pharmacies will not file the claim for You.) You can get a claim form from Us or the PBM. You must fill in the top section of the form and ask the Non-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, You must attach a detailed receipt to the claim form. The receipt must show:

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

You must pay the amount shown in the "Schedule of Cost Share and Benefits." This is based on the Maximum Allowed Amount as determined by Our normal or average contracted rate with Network Pharmacies on or near the date of service.

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 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 can have Your doctor send Prescriptions electronically, via fax or phone call, or You can submit written Prescriptions from Your doctor to the Home Delivery Pharmacy. Your doctor may also call the Home Delivery Pharmacy.

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 or check Our website at www.anthem.com for more details.

If You are taking a Maintenance Medication, You may get the first 30 day supply and one 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then contact the Home Delivery Pharmacy and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy. You will have to pay the full retail cost of any Maintenance Medication You get without registering Your choice each Year through the Home Delivery Pharmacy. You can tell Us Your choice by phone at 833-236-6196 or by visiting Our website at www.anthem.com.

When using Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery program, You can call Pharmacy Member Services toll-free at 833-236-6196.

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 department at 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 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. 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. We will cover the other Prescription Drug only if We agree that it is Medically Necessary and appropriate over the other drugs that are on the Prescription Drug List. We will make a coverage decision within 72 hours of receiving Your request. If We approve the coverage of the drug, coverage of the drug will be provided for the duration of Your Prescription, including refills. If We deny coverage of the drug, You have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving Your request. If the IRO approves the coverage of the drug, coverage of the drug will be provided for the duration of Your Prescription, including refills.

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

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

Drug Utilization Review

If there are patterns of over utilization or misuse of drugs, We will notify Your personal 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 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.

Therapeutic Equivalents

Therapeutic Equivalents is a 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 equivalent is right for You. For questions or issues about therapeutic drug equivalents, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Split Fill Dispensing Program

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

Drug Cost Share Assistance Programs

If You qualify for certain non-needs based drug Cost Share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance You pay for certain Specialty Drugs, the reduced amount You pay may be the amount We apply to Your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by a Network Provider. In addition, We may also enroll You in a program, the Cost Relief Program, that allows You to further reduce Your costs, and may eliminate Your out-of-pocket costs altogether. We will work with manufacturers to get the maximum Cost Share assistance You are eligible for and will manage enrollment and renewals on Your behalf.

Please note that We may increase the Cost Share listed in the "Schedule of Cost Share and Benefits" in order to take full advantage of Cost Share assistance that is available from drug manufacturers. Any increase in the Cost Share will not be more than 50% of the Maximum Allowed Amount. This will lower Plan costs but will not increase Your cost because any additional Cost Share will be offset by the Cost Share assistance.

Participation in this program is voluntary. If You currently take one or more Prescription Drugs included in this program, We will automatically enroll You in the program and send You a welcome letter, followed up with a phone call that provides specific information about the program as it pertains to Your medication. Whether You enroll in the Cost Relief Program or not, any non-needs based Cost Share assistance You receive will not accumulate to Your Deductible or Out-of-Pocket Limit.

If You or a covered family member are not currently taking, but will start a new Prescription Drug covered under this program, You can either contact Us or We will proactively contact You so that You can take full advantage of the program.

Some drug manufacturers will require You to sign up to take advantage of the assistance that they provide. In those cases, We will contact You to let You know what You need to do.

The list of Prescription Drugs covered by the Cost Relief Program may be updated periodically by the Plan. Please refer to Our website, www.anthem.com, for the latest list.

Opting Out

If You do not wish to participate in this program, You can opt out, and You will be responsible for a portion of the cost of the Specialty Drug as noted in the “Schedule of Cost Share and Benefits”.

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 Dental Care

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

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

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

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

Diagnostic and Preventive Services

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

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

- Bitewings - two sets per 12 month period.
- Full mouth (also called complete series) - one time per 60 month period.
- Panoramic - one time per 60 months.
- Periapicals, occlusals, and extraoral films are also covered.

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

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

Preventive Resin Restorations. Once per permanent tooth every 36 months.

Sealants. One sealant per tooth, unrestored permanent molars, every 36 months.

Space Maintainers and Recement Space Maintainers

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

Basic Restorative Services

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

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

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

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

Endodontic Therapy on Primary Teeth

- Pulpal therapy
- Therapeutic pulpotomy

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

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

Pin Retention

Therapeutic Drug Injection

Partial Pulpotomy for Apexogenesis. Covered on permanent teeth only

Endodontic Services

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

- Root canal therapy
- Root canal retreatment

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

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

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

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft
- Soft tissue allograft

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

- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft

Crown Lengthening

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions. Surgical removal of third molars is covered only when symptoms of oral pathology exists.

- Surgical removal of erupted tooth

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

Other Complex Surgical Procedures

- Alveoloplasty - in conjunction with extractions
- Alveoloplasty - not in conjunction with extractions
- Removal of exostosis - per site

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product. Covered one time per 36-month period.
- Excision of pericoronal gingiva
- Tooth reimplantation (accidentally evulsed or displaced tooth)
- Suture of recent small wounds up to five cm

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

Major Restorative Services

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

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

Onlays or Permanent Crowns. Covered one time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. If You choose to have another type of crown, You are responsible to pay for the difference plus any applicable Deductible and Coinsurance.

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

Inlay, Onlay or Crown Repair. Covered one time per 36 months. The narrative from Your treating dentist must support the procedure.

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

Restorative Cast Post and Core Build Up. Includes one post per tooth and one pin per surface. Covered one time per 60 months. Covered only if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

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

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

Prosthodontic Services

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

Bridges (fixed prosthodontic services). Covered one time per 60 months for the replacement of extracted permanent teeth. If You have an existing bridge, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to serve as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable

partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this Plan in the last 60 months.

The Plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the Plan may cover a partial denture instead of the bridge. If You still choose to get the bridge, You will be responsible to pay the difference in cost, plus any applicable Deductible and Coinsurance.

Tissue Conditioning

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

Repairs and Replacement of Broken Clasps

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

Denture Adjustments

Partial and Bridge Adjustments

Recement Bridge (fixed prosthetic)

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

Orthodontic Care

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

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

- Spacing between adjacent teeth that interferes with Your biting function.
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite.
- The position of Your jaw or teeth impairs Your ability to bite or chew.
- On an objective, professional orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care.

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

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

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

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

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

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

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

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

Pediatric Vision Care

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

Routine Eye Exam

This Contract covers a complete routine eye exam with dilation if 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 or supplemental testing.

WHAT IS NOT COVERED (EXCLUSIONS)

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

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

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 Providers located outside of Wisconsin 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 auto injections.
- 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, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bio-energetic 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.

Autism Spectrum Disorders. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Services which are not evidence-based;
- Acupuncture;
- Animal-based therapy including hippotherapy;
- Auditory integration training;
- Chelation therapy;
- Child care fees;
- Cranial sacral therapy;
- Custodial or respite care;
- Hyperbaric oxygen therapy;
- Special diets or supplements;
- Travel time by qualified Providers, qualified supervising Providers, qualified professionals, therapists or qualified paraprofessionals;
- Costs for the Facility or location, or for the use of a Facility or location, when treatment, therapy or services are provided outside of a Member's home;
- Claims We have determined are fraudulent; and
- Treatment provided by family members who are otherwise qualified Providers, qualified supervising Providers, therapists, qualified professionals or paraprofessionals for treatment provided to their own children.

Autopsies and Post-mortem Testing.

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

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 Contract.

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.

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

Compound Drugs. Compound Drugs.

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 Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to, myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

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

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

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

Delivery Charges. Charges for delivery of Prescription Drugs.

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

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

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes, but is not limited to, preventive care, diagnosis,

treatment of or related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- 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 Contract. 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. Doctor or other practitioners' charges including:

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending doctor.
- 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.

Doctor Stand-by Charges. For stand-by charges of a doctor.

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.)

Durable Medical Equipment. Covered Services do not include durable medical equipment except as specified as a Covered Service in this Contract. 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 Contract.
- 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. 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 Contract. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

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

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

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

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

Fraud, Waste, Abuse, and Other Inappropriate Billing. Services from a Non-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes a Non-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

Free Care. Free care services You would not have to pay for if You did not have this Plan. This includes, but is not limited to, government programs, services during a jail or prison sentence, services You get from Workers' Compensation, and services from free clinics.

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

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

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

Hearing Care. Related items such as batteries, cords, and other assistive listening devices, including but not limited to, frequency modulation systems, are not covered.

Hospice Care. The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements except as specified as a Covered Service in this Contract or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Human Growth Hormone. Human growth hormone.

Hyperhidrosis. For treatment of hyperhidrosis (excessive sweating).

Impotency. 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. For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

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.

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

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

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.

Non-authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified as a Covered Service in this Contract.

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 Contract. 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 Contract 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.

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

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

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

- Monthly treatment visits that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;

- Retreatment and/or services for any treatment due to relapse;
- Inpatient or Outpatient Hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthotic Appliances that Straighten or Re-shape a Body Part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.

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 Contract 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;
- 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.

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

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

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

Reconstructive Services. Reconstructive services except as specified as a Covered Service in this Contract, 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 Contract.

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, except as required by law.

Reversal of Sterilization. For reversal of sterilization.

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 Contract.

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

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

- Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us;
- Separate charges for services by professionals employed by a Facility which makes their services available;
- Not listed as covered under this Contract;
- Not prescribed, performed, or directed by a Provider licensed to do so.

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

- Amounts above the Maximum Allowed Amount for a service;
- Neurofeedback and related diagnostic tests;
- The following therapies:
    - group speech therapy; or
    - group or individual exercise classes or personal training sessions.

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

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

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

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

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

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

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

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

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

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

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

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

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

Wigs. Wigs regardless of the reason for the hair loss.

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, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the PBM.
- An Allergenic Extract or Vaccine.
- 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. Compound Drugs.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility. Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a doctor. This exclusion does not apply to drugs used with a diagnostic service, drugs given during chemotherapy in the office as 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.
- 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.
- New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and placed on a tier by Our Pharmacy and Therapeutics (P&T) Process.
- Nutritional or Dietary Supplements. Nutritional and/or dietary supplements, except as described in this Contract or that We must cover by law. This exclusion includes, but is not limited to,

nutritional formulas and dietary supplements that You can buy over-the-counter and those You can get without a written Prescription or from a licensed pharmacist.

- Off Label Use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onychomycosis Drugs. Drugs for onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be covered. Drugs, devices and products, or 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.
- Prescription Drugs used to Treat Infertility.
- 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 Dental Care

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

- Dental care for Members age 19 and older, except as specified as a Covered Service in this Contract.
- Dental services or healthcare services not specifically covered under the Contract (including any Hospital charges, Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, except as specified as a Covered Service in this Contract).
- Services of anesthesiologist, unless required by law.
- Anesthesia services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Contract.
- Biological tests for determination of periodontal disease or pathologic agents, except as specified as a Covered Service in this Contract.
- Collection of oral cytology samples via scraping of the oral mucosa, except as specified as a Covered Service in this Contract.
- Separate services billed when they are an inherent component of another Covered Service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.

- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the Effective Date of this Contract or received after the coverage under this Contract has ended.
- Dental services given by someone other than a licensed Provider (dentist or doctor) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), except as specified as a Covered Service in this Contract.
- Occlusal or athletic mouth guards.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.

Pediatric Vision Care

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

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

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 Contract.

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 Contract’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 Contract’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 Period.

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.”

The Network and Non-Network Deductibles are separate and do not apply toward each other.

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 Period. 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 Period.

Out-of-Pocket Limit Calculation

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

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

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

Once the applicable Non-Network Out-of-Pocket Limit is satisfied, no additional Cost Sharing will be required for the remainder of the Calendar Year, except for any charges over the Maximum Allowed Amount.

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

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 Contract.

Services Received from Non-Network Providers

Covered Services that are not obtained from a PCP, SCP or another Network Provider, or that are not Authorized Services will be considered a Non-Network Service. The only exceptions are Emergency Care, or Emergency ambulance services.

For services rendered by a Non-Network Provider, You are responsible for:

- The difference between the actual charge and the Maximum Allowed Amount except for Surprise Billing Claims, plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher Cost Sharing amounts.

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.

Allowable Amount Verification

You may contact Our Member Services Department prior to having a procedure performed to determine if the Provider's estimated charge is within Our Maximum Allowed Amount and what Your estimated Out-of-Pocket cost would be. You must provide Us with the following information:

1. The name of the Provider who will provide the service;
2. The name of the Facility where services will be provided;
3. The date services will be provided;
4. The Provider's estimate of the charges; and
5. The codes for the service under the Current Procedural Terminology (CPT) or Current Dental Terminology (CDT).

Although We can assist You with this pre-service information, the final Maximum Allowed Amount and Out-of-Pocket cost will be based on the actual claim submitted by the Provider.

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 Contract, e.g., Deductibles (if any) or Coinsurance. When You receive Covered Services from a Non-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless You receive a Surprise Billing Claim.

For services from a Non-Network Provider:

- In addition to any Deductible and/or Coinsurance/Copayments, the Non-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount except for Surprise Billing Claims;
- You may have higher Cost Sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done.

Maximum Allowed Amount

General

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

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

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims when You

receive Covered Services from a Non-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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

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 Provider or a Non-Network Provider.

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

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

Except for Surprise Billing Claims, We will calculate the Maximum Allowed Amount for Covered Services You receive from a Non-Network Provider, using one of the following:

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

Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount 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 a Non-Network Provider. In order for Us to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your out-of-pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

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

Your Cost Share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher Cost Sharing amounts or may have limits on Your benefits when using Non-Network Providers. Please see the "Schedule of Cost Share and Benefits" in this Plan for Your Cost Share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or Cost Share amounts may vary by the type of Provider You use.

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

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: Your Plan has a Coinsurance Cost Share of 20% for Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

- You choose a Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out-of-pocket

responsibility would be $300.

- You choose a Non-Network surgeon. The Non-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; Your Coinsurance responsibility for the Non-Network surgeon is 30% of $1500, or $450 after the Non-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Non-Network surgeon could bill You the difference between $2500 and $1500, so Your total out-of-pocket charge would be $450 plus an additional $1000, for a total of $1450.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, We may authorize the Network Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Network Provider. In such circumstances, You must contact Us in advance of obtaining the Covered Service. If We authorize a Network Cost Share amount to apply to a Covered Service received from a Non-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge unless Your claim involves a Surprise Billing Claim . 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 in Your State of residence. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Non-Network Provider for that Covered Service and We agree that the Network Cost Share will apply.

Your Plan has a $45 Copayment for Non-Network Providers and a $25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

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

Because the Non-Network Provider's charge for this service is $500, You may receive a bill from the Non-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 800-810-2583. Or You can call them collect at 804-673-1177.

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

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

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

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

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

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

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

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

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

Payment Authorization

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. 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 the Contract. 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 Non-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 Contract), 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 gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Notice of Claim and Proof of Loss

After You get Covered Services, We must receive written notice of Your claim in order for benefits to be paid.

- Network Providers will submit claims for You. They are responsible for ensuring that claims have the information We need to determine benefits. If the claim does not include enough information, We will ask them for more details, and they will be required to supply those details within certain timeframes.
- Non-Network claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Provider is not submitting on Your behalf, You will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, You can send a written request to Us, or contact Member Services and ask for a claim form to be sent to You. If You do not receive the claim form, You can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
    - Name of patient.
    - Patient's relationship with the Subscriber.
    - Identification number.
    - Date, type, and place of service.
    - Your signature and the Provider's signature.

  Non-Network claims must be submitted within 90 days. Failure to file a claim within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within such time, provided such proof is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one Year from the time the claim is required to be filed.

  The claim must have the information We need to determine benefits. If the claim does not include enough information, We will ask You for more details and inform You of the time by which We need to receive that information. Once We receive the required information, We will process the claim according to the terms of Your Plan.

  Please note that failure to submit the information We need by the time listed in Our request could result in the denial of Your claim, unless State or federal law requires an extension. Please contact Member Services if You have any questions or concerns about how to submit claims.

Payment of Benefits

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within 30 calendar days for clean claims filed electronically or filed on paper. "Clean claim" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If We fail to pay or deny a clean claim in 30 calendar days for a claim filed electronically; or in 30 calendar days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Wisconsin law.

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.

Claim Denials

If benefits are denied, in whole or in part, Anthem will send the Member a written notice within the established time periods described in the section "Payment of Benefits." The Member or the Member's duly authorized representative may appeal the denial as described in the "If You Have a Complaint or an Appeal" section. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim Appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

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

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.

Assignment

The coverage, rights, and benefits under this Contract 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 Contract 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 services from non-participating or Non-Network Providers could be balance billed by the non-participating or Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

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.

Payment Innovation Programs

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

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

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

IF YOU ARE COVERED BY MORE THAN ONE POLICY

The Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one Plan. Plan is defined below.

Please note that several terms specific to this provision are listed below. For this provision, the terms below will have the meanings, as describe in this section. Some of these terms may have different meanings, in other parts of the Contract. In the rest of the Contract, the meaning of a term can be determined based on the "Definitions" section, provided at the end of this Contract.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Coordination of Benefits Definitions

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: group and non-group insurance contracts health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means, the part of the contract providing the healthcare benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have healthcare coverage under more than one Plan.

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is Secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense is a healthcare expense, including Deductibles, Coinsurance and Copayments that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable Expense.

The Allowable Expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowed Amount.

The following are not Allowable Expenses:

1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3) If You are covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4) If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
5) The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, Precertification of admissions, and preferred Provider arrangements.
6) The amount that is subject to the Primary high-deductible health Plan’s Deductible, if We have been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed Panel Plan is a Plan that provides healthcare benefits primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

Except as provided in the paragraph below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is Secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule (1) Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an employee, Member, policyholder, Subscriber or retiree is the Primary Plan and the Plan that covers You as a Dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a Dependent; and primary to the Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, Member, policyholder, Subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

Rule (2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

(A.) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the Calendar Year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(B.) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the Dependent child's healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, Rule (2)(A) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent child, Rule (2)(A) above shall determine the order of benefits; or
- If there is no court decree assigning responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
    - The Plan covering the custodial parent;
    - The Plan covering the spouse of the custodial parent;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the spouse of the non-custodial parent.

(C.) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, Rule (2)(A) or Rule (2)(B) above shall determine the order of benefits as if those individuals were the parents of the child.

Rule (3) Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (4) COBRA or State Continuation Coverage. If You are covered under COBRA or under a right of continuation provided by State or other federal law, the Plan covering You as an employee, Member, Subscriber or retiree or covering the person as a Dependent of an employee, Member, Subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if Rule (1) above can determine the order of benefits.

Rule (5) Longer or Shorter Length of Coverage. The Plan that covered You as an employee, Member,

policyholder, Subscriber or retiree longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule (6) If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefit of This Plan

When This Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan Year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim.

Because the Allowable Expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other healthcare coverage.

If You are enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We have paid or for whom We have paid; or any other person or organization that may be responsible for the benefits or services provided for the Member. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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 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.

Other Government Programs

The benefits under this Contract shall not duplicate any benefits that Members are entitled to, or eligible

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

IF YOU HAVE A COMPLAINT OR AN APPEAL

The Grievance Process

We want Your experience with Us to be as positive as possible. There may be times, however, when You have a complaint. In those cases, please contact Member Services. We will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file a grievance, which is defined as follows:

Grievance

A grievance is a written complaint or dissatisfaction regarding the services or benefits You get from Us. The complaint may involve Our administration or claim practices, disenrollment proceedings, a determination of a diagnosis or level of service needed for the Evidence-Based treatment of Autism Spectrum Disorders, or denial of a claim that You think should be paid by Us. If You are notified in writing of an adverse determination or coverage denial, You will be advised of Your right to file a grievance and to request external review, if appropriate.

For purposes of this section:

- **Coverage Denial** means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Contract.
- **Adverse Determination** means Our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:
    - A determination that You are not eligible to participate in the Contract, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a Utilization Review;
    - A determination that the benefit is Experimental / Investigative or not Medically Necessary;
    - A determination that the benefit is not a covered benefit under the Contract; or
    - A determination that the benefit is excluded due to a source-of-injury exclusion, Network exclusion, or other limitation in the Contract.

Adverse determination includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit.

You, or someone on Your behalf, may file the grievance. The grievance must:

1) Be in writing; and
2) Provide Your Subscriber identification number, patient's name, date, and place of service, and reason You are asking for the review. If the grievance is not claim related, please include a description of the problem and the solution You are looking for.

The grievance should be sent to the following address:

For medical and Prescription Drug or Pharmacy Issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, GA 30348-5568

Dental Coverage Appeals

Please submit Appeals regarding Your dental coverage to the following address:
Anthem Blue Cross and Blue Shield
P.O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

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

Blue View Vision
P.O. Box 9304
Minneapolis, MN 55440-9304

It will help if You identify Your letter as a grievance. We will acknowledge the grievance within five business days of receiving it. We will examine all relevant facts including any materials or records that You submit. You may appear in person before the grievance committee to present written or oral information.

We will tell You of the time and place of the committee meeting at least seven calendar days before the meeting.

In addition, We will also provide You, free of charge, with any new or additional evidence We will consider, rely upon, or generate in connection with the claim, as well as Our rationale for making any adverse determination. We will provide this as soon as possible and sufficiently in advance of the date on which the final adverse determination is due, by law, to give You a reasonable opportunity to respond prior to that date.

You will continue to get coverage under the Contract pending the outcome of the grievance, as long as You remain eligible for coverage. If You have undertaken an ongoing course of treatment, We will only reduce or terminate it after giving You advance notice.

We will ensure that grievances are reviewed in a manner designed to ensure the independence and partiality of the individuals responsible for reviewing Your grievance (referred to as qualified reviewers). The qualified reviewers will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision.

After review, We will provide a written decision, including reasons, within 30 calendar days of receiving the grievance. If special circumstances require a longer review period, We will provide Our written decision within 60 calendar days of receiving the grievance. If We need the extra days, We will notify You of the reason why, and when a decision may be expected.

If We fail to resolve the grievance with the required timeframe, You may pursue external review as described later in this Contract. This option is not available, however, if Our failure to resolve the grievance is due to a de minimus violation that does not cause harm to You or is not likely to cause prejudice or harm to You, if the delay is for good cause or due to matters beyond Our control, and is part of an ongoing, good faith exchange of information between the You and Us.

Filing an Expedited Grievance

In certain circumstances, You may request that We review Your grievance within 72 hours. You may do this if the standard grievance process would include any of the following:

1) Serious jeopardy to Your life or health or Your ability to regain maximum function;
2) A situation where, in the opinion of a doctor with knowledge of Your medical condition, You would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance; or
3) A situation where, in the opinion of a doctor with knowledge of Your medical condition, that You must receive the treatment that is the subject of the grievance right away.

You may file an expedited grievance via a phone call to Us. You must give Us the same information listed above. We will, upon written request, mail or e-mail a copy of Your Contract to You or Your authorized representative as part of this process. We will resolve the expedited grievance within 72 hours of receiving it.

In addition, if Your care involves an urgent situation for which You are receiving an ongoing course of treatment, You may be allowed to proceed with an expedited external review at the same time as the

expedited grievance.

The External Review Process

You, Your authorized representative, or a Provider acting on Your behalf may request an external review of an adverse determination if the following criteria are met:

- The grievance process outlined above was completed or jointly waived by You and Us or We failed to make a determination within 60 days of receiving the written grievance or within 72 hours of receiving the request for an expedited grievance; and
- You were covered under this Contract on the date of service or, if a prospective denial, You are eligible to receive benefits under this Contract on the date the proposed service was requested.

In this section, several terms are defined as follows:

External Review means a review of Our decision conducted by an Independent Review Organization (IRO).

Independent Review Organization means an independent entity that reviews Our decisions. IROs are completely separate from Us.

Asking for External Review

If You wish to pursue external review, You or Your authorized representative must notify Our Grievance Department in writing at the following address:

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, GA 30348-5568

A written request 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 request 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 request 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.

If someone else is filing on Your behalf, You will need to submit a statement signed by You, the Member, authorizing that person to be Your representative.

We must receive the request within four months of the date that We denied Your grievance.

We will determine if Your request qualifies for external review and will refer all eligible requests to an Independent Review Organization (IRO). IROs are assigned on a rotating basis so that We do not have the same IRO for two consecutive external reviews. We will tell You in writing which IRO will conduct the review and tell You of Your right to submit additional information to the IRO within five days. If the IRO gets the information within five days they will include it in their review and send a copy to Us within one day. We will also send all information required for an external review to the IRO within three business days of assigning the IRO.

The IRO will send a written decision to You within 21 calendar days of getting all information needed from Us. An extension of up to 14 days may be allowed if agreed to by You and Us. In no event will the IRO take longer than 45 days to complete their review.

You will not be able to get an external review of an adverse determination if:

- Your adverse determination has previously gone through external review and the IRO found in

Our favor; and
- No new relevant clinical information has been sent to Us since the IRO found in Our favor.

Asking for an Expedited External Review

If the standard external review process would jeopardize Your life, health, or ability to regain maximum function, You may ask Us to expedite Your request for external review. If Your situation requires an expedited external review:

- We will notify the IRO within one day and send them Your information.
- The IRO will have two business days to review this material and request additional information. We will have two days to respond to this request.
- Once the IRO has all the necessary information, it will make a decision within 72 hours.

You may also ask for an expedited external reviews if You are requesting a review of a decision that a recommended or requested service is Experimental/Investigative and Your doctor certifies in writing that the requested service would be significantly less effective if not promptly initiated.

You may pursue an expedited external review while simultaneously pursuing an expedited grievance.

The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by You, Your authorized representative or a Provider acting on Your behalf. Requests for expedited external review will be sent by Us to the IRO within 24 hours of getting the request.

For expedited external review, the IRO will make a decision within 24 hours of getting all information required from Us. An extension of up to 24 hours may be allowed if agreed to by You and Us. We will give notice to the IRO and You the same day that the adverse determination has been assigned to an IRO for Expedited Review. In no event will the IRO take longer than 72 hours to complete their review.

The Importance of the IRO's Decision

The Independent Review Organization will provide You, Your treating Provider, the Office of the Commissioner of Insurance, and Us a decision which shall include:

- The findings for either Us or You regarding each issue under review;
- The proposed service, treatment, drug, device or supply for which the review was performed;
- The relevant provisions in the Contract and how applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to Independent Review Organizations are handled as confidential records.

The decision of the IRO will be binding on Us and You except to the extent that there are remedies available under applicable State or federal law.

Filing an OCI Complaint

You may resolve your problem by taking the steps outlined in the grievance and external review processes described above. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a State agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or You can call 800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

Legal Action

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within three Years of Our final decision on the claim or other request for benefits. You must file written proof of loss within 15 months of the date of service. 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.

Prescription Drug List Exception

Please refer to the section “Prescription Drug List” “What is Covered” section for the process for submitting an exception request for drugs not on the Prescription Drug List.

WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the 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 Contract 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 Wisconsin 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;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area applicable to this Contract.

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

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

6. Agree to pay for the cost of the 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 Qualified Health Plan through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange or through the Exchange that services the area in which the Dependent meets 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 means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole domestic partner and has been for 12 months or more; he or she is mentally competent; neither the Subscriber nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under State law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a. For purposes of this Contract, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.
    b. A domestic partner's or a domestic partner's child's coverage ends at the end of the month of the date of dissolution of the domestic partnership.
    c. To apply for coverage as domestic partners, both the Subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange.
3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children until age 26.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian until age 26.
5. A child of a covered Dependent (i.e., a grandchild of the covered Subscriber or the Subscriber's covered spouse) until the Dependent child reaches age eighteen (18).

Eligibility will be continued past the age limit in either of the following circumstances:

- For those already enrolled children who cannot work to support themselves by reason of intellectual or physical impairment. The child's impairment must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the child's eligibility. The Exchange must be informed of the child's eligibility for continuation of coverage within 31 days after the date the child would normally become ineligible. You must notify the Exchange if he or she is no longer eligible for continued coverage.
- For an unmarried child who was under age 27, a full-time student and was activated in the National Guard or in a reserve component of the United States armed forces if the child returns to full-time status at the end of the activated military service period.

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 Contract.

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

Open Enrollment

As established by the rules of the 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. For loss of Medicaid or CHIP coverage, enrollee has 90 calendar days to select a QHP;
- 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 will be covered for an initial period of 60 days from the date of birth. To continue coverage beyond the first 60 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Contract and You must pay Anthem timely for any additional Premium due or if You notify Us within one Year of the birth, You must pay all past due Premium plus interest at the rate of 5 1/2% per Year.

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

Court Ordered Health Coverage

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

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. The applicant's Effective Date is determined by the 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. For loss of Medicaid or CHIP coverage, complete application must be received within 90 days; and
4. In the case of new access to an ICHRA or new provision of a QSERHA, 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;
4. Termination of employment;
5. Reduction in the number of hours of employment;
6. Individual who no longer resides, lives or works in the Plan'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 Contract. 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 Contract, are subject to the condition that all such information is accurate. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

WHEN MEMBERSHIP ENDS (TERMINATION)

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

Termination of the Member

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

1. The Member terminates his or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, move outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange as an overage Dependent. Coverage for Dependent children ends on the last day of the Benefit Year in which the child turns age 26;
4. The Member fails to pay his or her Premium, and the grace period has been exhausted;
5. Rescission of the Member's coverage;
6. The QHP terminates or is decertified;
7. The Member changes to another QHP;
8. 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
9. 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; in this case, the last day of coverage will be the last day of the first month of the three month grace period; or
2. Any other applicable grace period.

Effective Dates of Termination

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

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) 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, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange as an

overage Dependent, coverage for Dependent children ends on the last day of the Benefit Year in which the child turns age 26.

5. 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.
6. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium is paid, consistent with existing State laws regarding grace periods.
7. 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.
8. The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria 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 Contract.
3. This Contract 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 Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two Years after adding an additional Dependent (excluding newborn children of the Subscriber added within 60 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependent did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Contract.

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

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

Discontinuation of Coverage

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

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the 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 Contract 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 Contract 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 Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium is due You give timely written notice to Us that the Contract is to be terminated. If You do not make the full Premium payment during the grace period, the Contract will be terminated on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the last day through which Premium is paid.

After Termination

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

Removal of Members

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

Refund of Premium

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

IMPORTANT INFORMATION ABOUT YOUR COVERAGE

Premium

Your Contract will renew each month if You pay Your Premium before the end of the grace period. The amount of Premium is printed on Your Premium notice; however, this amount is subject to change. We have the right to increase a Member's Premium at any time in the future, as allowed by law. We will not increase Premium for any reason without giving You at least 30 days written notice. If the Premium increase is 25% or more, We will give You at least 60 days written notice. We will then send You a new notice with the new Premium amount.

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

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

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

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

If Premium has been paid for any period of time after the date You terminate this Contract, We will refund that Premium to You. The refund will be for that period of time after Your coverage ends.

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

Changes in Premiums

The Premium rates are guaranteed for the 12 month period following the first day of the Calendar Year.

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 30 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.

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 authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- by mail using the address on Your Premium notice
- 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.

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, commercial entities with a direct or indirect financial interest in the benefits of the Contract 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 Contract 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.

Clerical Error

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

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 grievance process.

Entire Contract

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

This Contract, the application, and any Riders, Endorsements or Attachments, if any, constitute the entire Contract between the Plan and the Subscriber and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Subscriber and any and all statements made to the Subscriber by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Misstatement of Age

If the Premium for this Contract 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 Contract. 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 first priority for the full amount of Our lien and shall be entitled to payment, reimbursement and/or subrogation to the extent of the total amount of Our lien regardless of whether the total amount of the Recovery on account of the injury or illness is less than the actual loss suffered by You (or Your estate, parent, trustee or legal guardian) to the extent allowed 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

- You must reimburse Us the full amount of Our lien.
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.
- If You fail to repay Us, fail to cooperate or Our lien is otherwise not recovered by Us, We shall be entitled to deduct any of the unsatisfied portion of Our lien or the amount of Your Recovery, whichever is less, from any future benefit under the Plan.
- In the event that You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of Our lien or the amount of Your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.

- 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.
- The Plan cannot recover directly from You unless You have been made whole, if state law so requires. Whether a person has been made whole takes into account that person's degree of fault. A judge will decide any dispute as to whether the person has been made whole.

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 Contract. 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 authorization, signed by an officer of the Plan.

Worker's Compensation

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

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 Shares. 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.

Value-Added Programs

We may offer health or fitness related programs and products to Our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on Pharmacy products (over-the-counter drugs, consultations and biometrics). In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

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

Voluntary Clinical Quality Programs

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

Members' Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit Plan. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement.

It can be found on Our website FAQs. To access, go to www.anthem.com and select "Member Support". Under the Support column select "FAQs" > "Select My State" > "Pick Your State" > "Laws and Rights That Protect You" > "What are my rights as a member?". Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID Card.

DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Contract 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 (Anthem)

The company providing the coverage under this Contract. The terms We, Us and Our in this Contract 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/Year 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/Year 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 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.

Contract

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.

Controlled Substances

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

Copayment

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

Cost Share (Cost Sharing)

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

Covered Services

Services, supplies or treatments which are:

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

Deductible

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

Dentally Necessary Orthodontic Care

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

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 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.

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, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Contract. The Facility must be licensed as required by law, satisfy Our accreditation requirements, and approved by Us.

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. 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 Facility licensed as a Hospital as required by law that must satisfy Our accreditation requirements and

be approved by Us.

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 treatment for Mental Health and Substance Abuse conditions that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard Outpatient setting.

Interchangeable Biologic Product

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

Maintenance Medication

A drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number on the back of Your Identification Card 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 "How Your Claims Are Paid" section.

Medicaid

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

Medically Necessary/Medical Necessity

The services, supplies or equipment provided by a Provider that are required to diagnose or treat Your illness or injury. We determine whether a service, supply, or equipment is Medically Necessary based on the findings of a Utilization Review process and generally accepted medical practice. The fact that a Provider has prescribed, ordered, recommended or approved a service, supply or equipment does not in itself make it eligible for payment.

The service, supply or equipment is Medically Necessary if, as recommended by the treating Provider and determined by Our Medical Director or doctor designees, it is:

1) A health intervention for the purpose of treating a medical condition;
2) The most appropriate supply, equipment or level of service, site considering the potential benefits and harms to the patient;
3) Known to be effective in improving health outcomes. Effectiveness is determined by scientific

evidence; and

4) Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.
   For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting.

For purposes of this definition, "health intervention" is an item or services delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or physiological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Medicare

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

Member

The Subscriber and enrolled Dependent.

Mental Health and Substance Abuse

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 State high risk pool coverage, 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 Member Services at the telephone number on the back of Your Identification Card.

Network Provider

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

Non-Network 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 of Your pharmaceutical bill when You go to a Non-Network Pharmacy.

Non-Network Provider

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

Non-Network Providers.

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 Contract. 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 treatment for Mental Health and Substance Abuse conditions, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines within Your benefit program. The process includes 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.

Precertification

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

Premium

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

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

Provider

A professional or Facility licensed by law that gives healthcare services within the scope of that license, that must satisfy Our accreditation requirements and be approved by Us. Details on Our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/ . This includes any Provider that State law says We must cover when they give You services that State law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If You have a question about a Provider not described in this Contract please call the number on the back of Your Identification Card.

Psychologist

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

Qualified Health Plan or QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer (QHP Issuer)

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

Qualified Individual

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

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 Contract.

Rehabilitative Services

Healthcare services that help a person 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.

Residential Treatment Center/Facility

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Abuse conditions. The Facility must be licensed as a Residential Treatment Center in the State in which it is located, satisfy Our accreditation requirements, and be approved by Us.

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

used mainly for:

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

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty 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.

Service Area

The following Wisconsin counties: Adams, Ashland, Barron, Bayfield, Brown, Buffalo, Burnett, Calumet, Chippewa, Clark, Columbia, Crawford, Dane, Dodge, Door, Douglas, Eau Claire, Forest, Grant, Green, Green Lake, Iowa, Iron, Jackson, Kenosha, Kewanee, La Crosse, Lafayette, Langlade, Lincoln, Manitowoc, Marathon, Marquette, Menominee, Milwaukee, Monroe, Oconto, Outagamie, Ozaukee, Pepin, Pierce, Polk, Price, Racine, Richland, Rock, Rusk, Sauk, Sawyer, Shawano, Sheboygan, St. Croix, Taylor, Vernon, Vilas, Walworth, Washburn, Washington, Waukesha, Waupaca, Waushara, Winnebago, Wood.

Please note that zip codes may span more than one county. If the county is not included in the specific counties listed in the Service Area definition of this Contract, then the county is not part of the Service Area.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a Skilled Nursing Facility in the State in which it is located, satisfy Our accreditation requirements, and be approved by Us.

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.

Social Worker

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

Specialty Care Physician (Specialist or SCP)

A 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 Contract is issued.

Surgical Assistant

A healthcare practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

> Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

Surprise Billing Claims

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

- Emergency Services provided by Non-Network Providers;
- Covered Services provided by a Non-Network Provider at a Network Facility; and
- Non-Network air ambulance services.

Tax Dependent

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

Tax Filer

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.

Totally Disabled (or Total Disability)

A condition resulting from illness or injury in which, as certified by a doctor:

1) You, the Subscriber, are not able to perform any occupation or business for which You are reasonably suited by Your education, training, or experience. This also means that You are not, in fact, engaged in any occupation or business for wage or profit; and
2) The Dependent is unable to perform his or her normal activities of daily living.

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

Compare Health Services Insurance Corporation and Blue Cross Blue Shield of Wisconsin dba Anthem Blue Cross and Blue Shield (“Anthem”).

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

Get help in your language

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

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the 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 nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. (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.