Certificate of Coverage

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

Preferred Blue PPO

With Health Savings Account (HSA)

For The Small Group SHOP Marketplace

What You Need to Know about Your Group Preferred Provider Organization (PPO) Managed Health Care Plan

This insured health care plan is under the jurisdiction of the New Hampshire Insurance Department.

IMPORTANT INFORMATION. THIS CERTIFICATE REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO THE HEALTH INSURANCE CERTIFICATE.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services. The toll-free telephone number is 1-855-748-1805.

This health plan is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem).

Anthem is located at 1155 Elm Street, Suite 200, Manchester, New Hampshire 03101-1505

Our toll-free telephone number is 1-855-748-1805

The Member Services fax number is 1-855-414-9998
Please visit Anthem’s website at 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 Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

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

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

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

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and / or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. This means you will be responsible for all Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. 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.

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

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

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Member Satisfaction Services, Appeals and External Review Procedures" section of this Benefit Book.

Provider Directories

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

Transparency Requirements

Anthem provides the following information on its website (i.e., 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 1-855-748-1805.

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

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

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact Member Services at 1-855-748-1805 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 health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at 1-855-748-1805 or refer to our website, www.anthem.com.

Additional Federal Notices

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

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

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

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

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

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (Please see the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call us at 1-855-748-1805.

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance use disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance use disorder benefits cannot set day / visit limits on mental health or substance use disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance use disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out-of-pocket expenses on mental health and substance use disorder benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. Anthem makes determinations about Medical Necessity for mental health, substance use disorder, medical and surgical benefits according to the definition of "Medical Necessity (Medically Necessary)" as stated in the "Definitions" section of this Booklet. Medical Necessity criteria are available upon request.

Special Enrollment Notice

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

If you have a new Dependent as a result of marriage, you may be able to enroll yourself and Your Dependents. However, you must request Special Enrollment within 31 days after the marriage.

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

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

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

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

PLEASE NOTE: An enrolled Subscriber may add new Dependents (a new spouse, newborn child, adopted child or a child placed in your home for adoption) to his or her membership during initial enrollment periods without Special Enrollment and without waiting for the next Open Enrollment period. Initial Enrollment is explained in the "Eligibility and Enrollment – Adding Members" section. This Special Enrollment Notice describes the terms under which you and any eligible Dependent who declined initial enrollment may enroll *before* your Group's next Open Enrollment Period.

To request special enrollment or obtain more information, call Member Services at 1-855-748-1805 or contact the Group.

Statement of ERISA Rights

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

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

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

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

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

Introduction

Welcome to Anthem!

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

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

Your Group has agreed to be subject to the terms and conditions of Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

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

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Health Plans of New Hampshire, Inc. operating as Anthem Blue Cross and Blue Shield (Anthem). The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services. The toll-free telephone number is 1-855-748-1805. 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!

High-Deductible Health Plan for Use with Health Savings Accounts

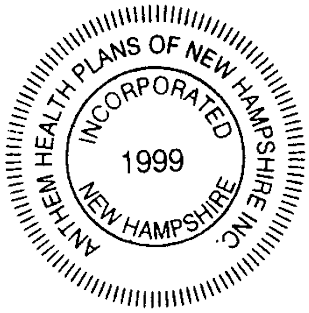
This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the New Hampshire Insurance Department does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.

How to Get Language Assistance

Anthem is committed to communicating with 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, 1-855-748-1805 and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY / TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

Please see the "Get Help in Your Language" section for additional information.

Maria M. Proulx
President and General Manager
New Hampshire



Kathleen S. Kiefer
Corporate Secretary

This health care plan is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem). Anthem is a stock corporation and licensed Accident and Health insurer in the State of New Hampshire. The benefits described in this Booklet are provided in accordance with requirements of New Hampshire statutes applicable to Accident and Health Insurance. Anthem is an independent licensee of the Blue Cross and Blue Shield Association.

Table of Contents

Schedule of Benefits

Anthem Silver Preferred Blue PPO 5000/20%/7250 w/HSA WH

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

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

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

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

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

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

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

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

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26 Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	**In-Network**	**Out-of-Network**
Per Member	**$5,000**	**$10,000**
Per Family	**$10,000**	**$20,000**

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

The In-Network and Out-of-Network Deductibles are separate and cannot be combined.

When a Member's Deductible is met, no further Deductible is required for that Member for the remainder of the Benefit Period. When a family Deductible is met, no further Deductible is required for the family for the remainder of the Benefit Period.

No one Member may contribute more than his or her individual Deductible toward meeting the family Deductible.

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	**80%**	**60%**
Member Pays	**20%**	**40%**

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. Except for Surprise Billing Claims, if you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
Per Member	**$7,250**	**$14,500**
Per Family	**$14,500**	**$29,000**

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

This plan is meant to be used with a qualified health savings account (HSA). The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. When a Member's Out-of-Pocket Limit is satisfied, the Member will not have to pay additional Deductible, Coinsurance or Copayments for the rest of the Benefit Period.

When a family Out-of-Pocket Limit is met, no family Member will have to pay additional Deductible, Coinsurance or Copayments for the rest of the Benefit Period. No one Member may contribute more than his or her Out-of-Pocket Limit toward meeting the family Out-of-Pocket Limit.

The Out-of-Pocket Limit does not include your premium, amounts over the Maximum Allowed Amount or charges for non-covered services. Adult Vision and Adult Dental benefits are also not included in the Out-of-Pocket Limit.

Important Notice about Your Cost Shares

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (i.e., in a Doctor's office, at an outpatient Hospital Facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a Doctor's office, an outpatient Hospital Facility, or during an Inpatient Hospital stay. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a Hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Acupuncture 20 visits per Benefit Period	Benefits are based on the setting in which Covered Services are received.	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air, and Water) **Emergency Services**	20% Coinsurance after Deductible	
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and / or Copayment.		
Ambulance Services (Ground, Air, and Water) **Non-Emergency Services**	20% Coinsurance after Deductible	
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. **Important Note:** All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used.		

Benefits	In-Network	Out-of-Network
Autism Services Benefits are available for the treatment of pervasive developmental disorder or autism.		
• Outpatient / office services provided by a licensed professional	Benefits are based on the setting in which Covered Services are received, and the type of provider who renders these services.	
• Physical, occupational and speech therapy	Benefits are based on the setting in which Covered Services are received.	
• Applied behavioral analysis Medically Necessary services for Members with pervasive developmental disorder or autism in the office setting.	$25 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Prescription drugs	Covered under "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" later in this Schedule.	
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Cardiac Rehabilitation	Benefits are based on the setting in which Covered Services are received.	
Cellular and Gene Therapy Services Precertification required	Benefits are based on the setting in which Covered Services are received.	
Chemotherapy	Benefits are based on the setting in which Covered Services are received.	
Chiropractor Services		
• Office visits	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
Chiropractor office visit Benefit Maximum	36 visits per Benefit Period In- and Out-of-Network combined	
• Diagnostic labs (non-preventive) furnished by a chiropractor	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• X-ray services furnished by a chiropractor	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Court Ordered Services	Benefits are based on the setting in which Covered Services are received.	
Dental Services For Members Through Age 18 **Note:** To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at 1-800-627-0004. Each Member must pay a combined In- and Out-of-Network Deductible of $50 per Benefit Period for all Covered Services other than Diagnostic and Preventive. This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan.		
• Diagnostic and Preventive Services	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Fluoride Treatments (topical application or fluoride varnish), covered 2 times per 12-month period	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Basic Restorative Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Services for Members Age 19 and Older **Note:** To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at 1-800-627-0004. Each Member must pay a combined In- and Out-of-Network Deductible of $50 per Benefit Period for all Covered Services other than Diagnostic and Preventive. This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan.		
Dental Services for Members Age 19 and Older Benefit Maximum	$1,000 per Benefit Period In- and Out-of-Network combined	

Benefits	In-Network	Out-of-Network
• Diagnostic and Preventive Services	No Copayment, Coinsurance or Deductible	No Copayment, Coinsurance or Deductible
• Basic Restorative Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care	Not covered	Not covered
Dental Services (All Members / All Ages) (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments.)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Self-Management Education Programs, and Supplies Screenings for gestational diabetes are covered under “Preventive Care.” Benefits for diabetic education are based on the setting in which Covered Services are received.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis / Hemodialysis	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Durable Medical Equipment (DME), Medical Devices, and Supplies		
• Durable Medical Equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Enteral Formula and modified low protein food products	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Hearing aids	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Orthotics	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prosthetics	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prosthetic Limbs	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Bone-Anchored Hearing Aids / Cochlear Implants	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Scalp Hair Prosthesis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Medical Surgical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$350 Copayment per visit after Deductible Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	20% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	$40 Copayment per visit after Deductible	
• Other Facility charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	
As described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance		

Benefits	In-Network	Out-of-Network
and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable. Please refer to the Notice at the beginning of this Booklet for more details.		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.	
Hearing Services (Received from a Provider other than a medical equipment supplier)		
• Inpatient and outpatient / office services to diagnose and treat ear disease or injury	Benefits are based on the setting in which Covered Services are received.	
• Hearing Aids	Benefits are based on the setting in which Covered Services are received.	
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Specialty Prescription Drugs administered by a Provider in your home	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapy Services (PT / OT / ST) limits do not apply when these services are rendered in the home as part of home health care. Manipulation Therapy will not be covered when rendered in the home.		
Home Infusion Therapy	See "Home Health Care."	
Hospice Care		
• Home Hospice Care	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Bereavement	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Inpatient Hospice	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Outpatient Hospice	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Respite Care	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services Precertification required	Benefits are based on the setting in which Covered Services are received.	Out-of-Network Benefits are not available
– Transportation and Lodging Limit – Covered, as approved by us, up to $10,000 per transplant.	20% Coinsurance after Deductible	Out-of-Network Benefits are not available
– Donor Search Limit Covered, as approved by us, up to $30,000 per transplant.	20% Coinsurance after Deductible	Out-of-Network Benefits are not available
Infertility Services	Benefits are based on the setting in which Covered Services are received.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility (including Delivery)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Important Note for Newborn / Maternity Stays: If the newborn needs services, they will be covered for 31 days from birth without additional premium or cost share. If the subscriber wishes to extend coverage for the newborn beyond 31 days, the newborn must be enrolled during the 31-day period and be subject to additional premium, if any, from day 32 to the end of the plan year.		
• Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (includes services in an outpatient day rehabilitation program) Benefit Maximum	100 days per Benefit Period In- and Out-of-Network combined	
• Mental Health / Substance Use Disorder Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Residential Treatment Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services Benefit Maximum for Skilled Nursing Facility and Physical Rehabilitation Facility services	100 Skilled Nursing Facility days and 100 Physical Rehabilitation Facility days per Benefit Period In- and Out-of-Network combined	
• Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting. In addition, please refer to the "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details and the "Autism Services" section earlier in this Schedule.		
Occupational Therapy	Benefits are based on the setting in which Covered Services are received.	
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" or "Outpatient Facility Services - Site of Service Ambulatory Surgery and Radiology Centers" section, based on where services are received. Please refer to those sections for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Preferred Primary Care Physician Provider (PCP) (including In-Person and / or Virtual Visits)	In-Person Visits: No Copayment or Coinsurance after Deductible Virtual Visits: No Copayment or Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
• Primary Care Physician / Provider (PCP) (including In-Person and / or Virtual Visits)	In-Person Visits: $40 Copayment per visit after Deductible Virtual Visits: $40 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Provider (Including In-Person and / or Virtual Visits)	In-Person Visits: $25 Copayment per visit after Deductible Virtual Visits: $25 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP) (including In-Person and Virtual Visits)	In-Person Visits: $60 Copayment per visit after Deductible Virtual Visits: $60 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Additional Telehealth / Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$60 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Retail Health Clinic Visit	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
Maternity and Reproductive Health Services		
• First office visit to diagnose a pregnancy	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Prenatal Office Visits to an In-Network Provider who specializes in obstetrics and gynecology	Routine prenatal office visits and other preventive prenatal care and screenings are covered under “Preventive Care.”	40% Coinsurance after Deductible
• Maternity Visits (Global fee for the Ob-Gyn’s prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Acupuncture	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Nutritional Counseling for Eating Disorders	$25 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum) – Includes travel and rabies vaccine.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Labs (other than reference labs)	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy Services (Habilitative & Rehabilitative):		
– Physical Therapy	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
– Speech Therapy	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on physical, occupational and speech therapy Benefit Maximums.		
– Chiropractic / Osteopathic Manipulative Therapy	$40 Copayment per visit after Deductible	40% Coinsurance after Deductible
– Early Childhood Intervention Services	No Copayment or Coinsurance after Deductible	No Copayment or Coinsurance after Deductible
Early Childhood Intervention Services office visit Benefit Maximum	40 visits per Benefit Period	
– Cardiac Rehabilitation	$60 Copayment per visit after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	$60 Copayment per visit after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
– Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Also, see “Autism Services” earlier in this Schedule		
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	
Outpatient Facility Services		
• Acupuncture	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Applied Behavior Analysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including anesthesiologist, pathologist, radiologist, surgical assistant)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Shots / Injections (other than allergy serum) – Includes travel and rabies vaccine.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests: EKG, EEG, etc.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy:		
– Physical Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Speech Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on physical, occupational and speech therapy Benefit Maximums.		
– Chiropractic / Osteopathic Manipulative Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Early Childhood Intervention Services	No Copayment or Coinsurance after Deductible	No Copayment or Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Also, see “Autism Services,” “Emergency Room Services,” and “Mental Health and Substance Use Disorder Services” earlier in this Schedule and “Site of Service Ambulatory Centers” and “Urgent Care Services” below.		

Benefits	In-Network	Out-of-Network
Outpatient Services at Site of Service Lab Providers, and Ambulatory Surgery and Radiology Centers Site of Service providers are limited to locations in New Hampshire and some adjoining counties in bordering states. Please see www.anthem.com for a list of preferred Site of Service Lab Providers, Ambulatory Surgery and Radiology Centers or call us at 1-855-748-1805.		
• Ambulatory Surgery Center - Facility Surgery	$250 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Ambulatory Surgery Center – Surgery Lab	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Ambulatory Surgery Center – Surgery X-ray	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Ambulatory Surgery – Ancillary Services	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Charges (including anesthesiologist, pathologist, radiologist, surgery, surgical assistant)	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Site of Service Lab Provider – Diagnostic Lab	No Copayment or Coinsurance after Deductible	40% Coinsurance after Deductible
• Radiology Center - Diagnostic X-rays	$150 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Radiology Center - Advanced Diagnostic Imaging by a preferred radiology Provider (including Radiologist charges, MRIs, CAT scans)	$250 Copayment per day after Deductible	40% Coinsurance after Deductible
Physical Therapy	Benefits are based on the setting in which Covered Services are received.	
Preventive Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits" section.	
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Please see the "What's Covered" section of your Certificate for additional detail on IRS guidelines.		
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices, and Supplies."	
Pulmonary Therapy	Benefits are based on the setting in which Covered Services are received.	
Radiation Therapy	Benefits are based on the setting in which Covered Services are received.	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.	
Respiratory Therapy	Benefits are based on the setting in which Covered Services are received.	
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	Benefits are based on the setting in which Covered Services are received.	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximums	Benefit Maximums are for office and outpatient visits combined	
• Physical Therapy / Occupational Therapy / Speech Therapy	60 combined visits in all Outpatient settings per Benefit Period	
(Habilitative and Rehabilitative)		
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice, Home Care, Early Childhood Intervention Services or Mental Health and Substance Use Disorder Services benefits.		
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.” Out-of-Network Benefits are not applicable.	
Urgent Care Services (Office & Home* Visits)		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	$100 Copayment per visit after Deductible	40% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum) -Includes rabies vaccine.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Labs (other than reference labs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
If you see an Out-of-Network Provider, that Provider may also bill you for any charges over the Plan's Maximum Allowed Amount. If you get Urgent Care at a Hospital or other Outpatient Facility, please refer to "Outpatient Facility Services" for details on what you pay.		
Virtual Visits (from Virtual Care only Providers)		
• Virtual Visits (including Primary Care) from Virtual Care-Only Providers (Medical Services)	From In-Network Virtual Care-Only Providers including K Health: $25 Copayment per visit after Deductible	Please refer to the "Office and Home Visits" section.
	From In-Network Virtual Care-Only Providers including LiveHealth Online: $25 Copayment per visit after Deductible	Please refer to the "Office and Home Visits" section.
• Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services)	$25 Copayment per visit after Deductible	Please refer to the "Office and Home Visits" section.
• Virtual Visits from Virtual Care-Only Providers (Specialty Care Services)	$60 Copayment per visit after Deductible	Please refer to the "Office and Home Visits" section.
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services For Members Through Age 18		
Note: To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call Member Services at 1-866-723-0515. Out of Network providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
• Routine Eye Exam Limited to one exam every Benefit Period.	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
• Standard Plastic Lenses Available only if the contact lenses benefit is not used. Limited to one set of lenses per Benefit Period per Member.		
Single Vision	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount

Benefits	In-Network	Out-of-Network
Bifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Trifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Standard Progressive	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Lenticular	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Additional Lens Options: Covered lenses include factory scratch coating, standard polycarbonate, standard photochromic lenses, UV coating, gradient tinting, oversized, and glass-grey #3 prescription sunglass lenses at no additional cost when received from In Network providers.		
• Frames Limited to one frame from the Anthem Formulary per Benefit Period per Member.	$0 Copayment, Anthem formulary	$0 Copayment up to the Plan's Maximum Allowed Amount
• Contact Lenses Available only if the eyeglass lenses benefit is not used. Elective or non-elective contact lenses from the Anthem formulary are covered once per Benefit Period per Member.		
• Elective Contact Lenses (Conventional or Disposable)	$0 Copayment, Anthem formulary	$0 Copayment up to the Plan's Maximum Allowed Amount
• Non-Elective Contact Lenses	$0 Copayment, Anthem formulary	$0 Copayment up to the Plan's Maximum Allowed Amount
• Low Vision Low vision benefits are only available when received from Blue View Vision Providers.		
Comprehensive Low Vision Exam once per Benefit Period	$0 Copayment	Not covered
Optical / Non-optical Aids / Supplemental Testing limited to one occurrence of either optical / non-optical aids or supplemental testing per Benefit Period	$0 Copayment	Not covered

Benefits	In-Network	Out-of-Network
Vision Services For Members Age 19 and Older		
Note: To get the In-Network benefit, you must use Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call Member Services at 1-866-723-0515. Out-of-Network providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
• Routine Eye Exam Limited to one exam every Benefit Period.	$20 Copayment	Reimbursed up to $30
• Standard Plastic Lenses Available only if the contact lenses benefit is not used. Limited to one set of lenses per Benefit Period.		
Single Vision	$20 Copayment	Reimbursed up to $25
Bifocal	$20 Copayment	Reimbursed up to $40
Trifocal	$20 Copayment	Reimbursed up to $55
Photochromic add-on	Reimbursed up to $75 in addition to lens Copayment	Not covered
Note: In-Network, lenses include factory scratch coating at no additional cost.		
• Frames Limited to one set of frames per Benefit Period.	Reimbursed up to $130	Reimbursed up to $45
• Contact Lenses Available only if the eyeglass lenses benefit is not used. Limited to one set of contact lenses per Benefit Period.		
• Elective Contact Lenses (Conventional or Disposable) Limited to one set of contact lenses per Benefit Period.	Reimbursed up to $80	Reimbursed up to $60
• Non-Elective Contact Lenses Limited to one set of elective or non-elective contact lenses per Member, every other Benefit Period.	$0 Copayment	Reimbursed up to $210

Benefits	In-Network	Out-of-Network
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and / or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	Not covered
Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits Except as required by law for “Preventive Care” pharmacy services, each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance or Deductible) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount. As required by law, “Preventive Care” pharmacy services are covered in full when furnished by an In-Network Pharmacy with a Prescription from your Doctor. **Day Supply Limitations –** Prescription Drugs will be subject to various day supply and quantity limits. Retail Pharmacy: You may obtain up to a 90-day supply of Maintenance Medications from a Retail Maintenance Pharmacy. You may also obtain up to a 90-day supply of Maintenance Medications from other Retail Pharmacies, provided that the Prescription is for a Covered Service, the quantity is ordered by your Physician, does not require Prior Authorization from Anthem and you can demonstrate that you have taken the Drug for a continuous period of one year. Otherwise, Retail Pharmacy and Specialty Pharmacy purchases may be limited to a 30-day supply per fill or refill. Home Delivery (Mail Order) Pharmacy: You may obtain up to a 90-day supply of Maintenance Medications from the Home Delivery (Mail Order) Pharmacy. Law regulates supplies of controlled substances. To be eligible for benefits, they must be purchased at a Retail Pharmacy. They cannot be purchased from a Home Delivery Pharmacy.		
PreventiveRx Plus Note: The Deductible does not apply to Prescription Drugs on the PreventiveRx Plus List when you use an In-Network Pharmacy.		
Level 1 Retail Pharmacy Copayments / Coinsurance		
Tier 1a Prescription Drugs	$3 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Tier 1b Prescription Drugs	$25 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 2 Prescription Drugs	$80 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 3 Prescription Drugs	30% Coinsurance to a maximum of $400 after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 4 Prescription Drugs	40% Coinsurance to a maximum of $550 after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Level 2 Retail Pharmacy Copayments / Coinsurance		
Tier 1a Prescription Drugs	$13 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 1b Prescription Drugs	$35 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 2 Prescription Drugs	$90 Copayment after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 3 Prescription Drugs	40% Coinsurance to a maximum of $500 after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Tier 4 Prescription Drugs	50% Coinsurance to a maximum of $650 after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Home Delivery Pharmacy Copayments / Coinsurance		
Tier 1a Prescription Drugs	$6 Copayment after Deductible per 90-day supply, per prescription.	50% Coinsurance after Deductible
Tier 1b Prescription Drugs	$50 Copayment after Deductible per 90-day supply, per prescription.	50% Coinsurance after Deductible
Tier 2 Prescription Drugs	$160 Copayment after Deductible per 90-day supply, per prescription.	50% Coinsurance after Deductible
Tier 3 Prescription Drugs	30% Coinsurance to a maximum of $800 after	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Tier 4 Prescription Drugs	Deductible per 90-day supply, per prescription. 40% Coinsurance to a maximum of $550 after Deductible per 30-day supply, per prescription.	50% Coinsurance after Deductible
Specialty Drug Copayments / Coinsurance Please note that certain Specialty Drugs are only available from the Network Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy that is not a Network Specialty Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from the Network Specialty Pharmacy, you will have to pay the same Deductible, Copayments and Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
Orally Administered Anti-Cancer Medications Cost Sharing Limitation As required by law, your share of the cost for orally administered anti-cancer medications will not exceed your Deductible plus $200 per 30-day supply, per prescription, provided that an intravenously administered or injected anti-cancer medication is not medically appropriate. The Deductible plus the $200 cost sharing limitation applies to prescriptions furnished by an In-Network Retail Pharmacy, Home Delivery (Mail Order) Pharmacy or by the Specialty Pharmacy.		
Insulin Drugs Used to Treat Diabetes The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $30 per prescription for a 30-day supply when obtained from a Network Retail Pharmacy. The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of $90 per prescription for a 90-day supply when obtained from a Network Home Delivery Pharmacy.		

How Your Plan Works

Introduction

Your Plan is a Preferred Provider Organization (PPO) Plan

The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more out-of-pocket costs.

To find an In-Network Provider for this Plan, please see "How to Find a Provider in the Network," later in this section.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be based on the In-Network level.

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. Anthem's definition of "Medical Necessity" is stated in the "Definitions" section.

Primary Care Physicians (PCP) / Providers

Selecting a Primary Care Physician

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

PCPs include general practitioners, internists, family practitioners, Advanced Practice Registered Nurses (APRN), pediatricians and geriatricians or any other practice allowed by the plan. Each member of a family may select a different PCP. 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 at 1-855-748-1805 or refer to our website, www.anthem.com.

Preferred Primary Care Providers / Programs

Anthem has partnered with select Primary Care Providers to offer lower Member cost sharing. We have partnered with these Providers, who are part of our Preferred Primary Care Program, because they have demonstrated success in lowering the cost of care and improving the quality of our Members' health care. These Providers agree to coordinate much of your care, and will prepare care plans for Members who have multiple, complex health conditions.

These Providers are identified as "Preferred Primary Care Providers" and have met certain efficiency and quality requirements and measures identified by nationally recognized organizations such as the National Committee on Quality Assurance (NCQA), the American Diabetes Association (ADA), the American Academy of Pediatrics (AAP) and many others. We encourage you to choose these Preferred Primary Care Providers whenever possible. For the most up-to-date information about New Hampshire Preferred Primary Care Providers, please visit Anthem's website, www.anthem.com. Or, you may contact Member Services for assistance at 1-855-748-1805.

First - 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 pick a PCP, set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

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

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

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

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

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

If you have any questions about Covered Services, call Member Services for assistance at 1-855-748-1805.

In-Network Provider Services

For services from In-Network Providers:

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

2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

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

After Hours Care

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

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to that section for further details.

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.

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and / or Coinsurance / Copayments, unless your claim involves a Surprise Billing Claim;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and / or Copayments) unless your claim involves a Surprise Billing Claim;

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay for non-Covered Services;

5. You may have to file claims; and

6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in Anthem's network.

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

- Search for a Provider in our mobile app.

- 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. The toll-free Member Services telephone number is 1-855-748-1805.

- 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 Member Services for assistance. The toll-free Member Services telephone number is 1-855-748-1805. TTY / TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Continuity of Care

If your In-Network Provider leaves our network for any reason other than termination for cause, retirement or death, or if coverage under this Plan ends because your Group's Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that Provider and still get In-Network benefits until treatment is complete or for 90 days, whichever is shorter. If you wish to continue seeing the terminating Provider, you or your Doctor should contact Member Services for details.

"Active treatment" means ongoing courses of treatment (including treatments for mental health and substance use disorders) for:

1) An ongoing course of treatment for a life-threatening condition,
2) An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits),
3) An ongoing course of treatment for pregnancy through the postpartum period, or
4) An ongoing course of treatment for a health condition for which the terminating Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes.

Your Cost-Shares

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

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out-of-Pocket amounts under that other plan. This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with Anthem began, or to people who join the Group later.

If your Group moves from one Anthem plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other Anthem Plan immediately before enrolling in this Plan with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of Anthem's Plans, and you change from one Plan to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out-of-Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other Anthem Plans or carriers in addition to ours, and you change Plans or carriers to enroll in this Plan with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this plan at the beginning of a Benefit Period;
- You change from one of Anthem's individual policies to a group plan;
- You change employers; or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with Anthem.

The BlueCard® Program

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

Identification Card (ID Card)

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

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental / Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of Medically Necessary health care by reviewing the use of treatments and, when proper, the level of care including the setting and / or place of service where 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 reviewed, services that can be safely given to you in a lower level of care, setting or place of service will not be Medically Necessary if they are given to you in a higher level of care, setting or place of service. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

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

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if you have not tried other clinically equivalent treatments that are Medically Necessary as defined in the "Definitions" section. "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 Member Services for assistance at 1-855-748-1805.

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 / Investigational as those terms are defined in this Booklet.

    No Precertification will be required for the first 2 routine outpatient visits of an episode of care for assessment and care for a Substance Use Disorder.

    For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed

unless there is a problem and / or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48 / 96 hours require precertification.

- **Continued Stay 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 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 has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained or a Precertification review was not performed. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Services given by a New Hampshire In-Network Provider. Typically, In-Network New Hampshire Providers know which services need Precertification or notification and will get any Precertification when needed or ask for a Precertification, even though it is not required. In-Network New Hampshire 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 Anthem to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network / Non-Participating	Member	• 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.**
For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

Call Anthem at 1-800-531-4450 to request Precertification or to notify Anthem for the following services. Or, call Member Services at 1-855-748-1805 for assistance with your Precertification request or emergency admission notification.

If you do not obtain Precertification or make notice as required and Anthem later determines that your care was not Medically Necessary, was not a Covered Service as stated in this Booklet, was subject to an exclusion stated in this Booklet or was not for an Emergency (Emergency Medical Condition) as applicable, then no benefits will be available and you will be responsible for the full cost of your care.

1. **Inpatient Admissions.**

- **Non-emergency Inpatient Admissions** - You must obtain Precertification from Anthem at least seven days *before* the day you are admitted to a Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility for non-emergency care. A non-emergency admission is any Inpatient admission that is not for an Emergency (Emergency Medical Condition) as defined in the "Definitions" section of this Booklet. Non-emergency admissions include but are not limited to elective, scheduled or planned Inpatient admissions.

  This Precertification requirement includes but is not limited to non-emergency Inpatient admissions for surgery such as bariatric surgery, human organ and bone marrow / stem cell transplants, and for Inpatient mental health and substance use care. This requirement also applies to obstetrical admissions and scheduled caesarian section deliveries that are not routine maternity admissions as described under the "Maternity Admissions" bullet below.

- **Maternity Admissions** - Precertification is not required for routine labor / childbirth admissions. However, if there is a complication in the delivery that extends your maternity admission and / or the mother and baby are not sent home at the same time, you or someone acting for you, must contact Anthem for Precertification within 48 hours after the first additional Inpatient day begins or as soon as reasonably possible after the 48 hour period.

- **Emergency Admissions** - Precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

- **For Substance Use Disorder admissions** for short-term stabilization and withdrawal management, you, your authorized representative or your attending Doctor must call Anthem's hot-line on the back of your ID Card to speak with an Anthem medical clinician or licensed alcohol and drug counselor who will assist in determining the Medically Necessary level of care. Anthem's decision will be made as soon as practicable upon receipt of your attending Doctor's clinical information but in no event more than 6 hours of receiving such information. Until the hotline determination is made, benefits will be available for Substance Use Disorder Services at a Medically Necessary level of care consistent with the latest edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, as developed by the American Society of Addiction Medicine (ASAM).

2. **Outpatient Services** - You must call Anthem for Precertification at least 7 days *before* receiving any of the following outpatient services.

- Ablative technics for treatment of Barrett's Esophagus
- Blepharoplasty, blepharoptosis, repair and brow lift
- Breast surgery (female and male excluding breast biopsy
- Cochlear implant and auditory brain stem implant
- Coronary angiography and cardiac catheterization in an outpatient setting.
- Coronary Angiography, Echo cardiology, stress echocardiography (SE), transesophageal echocardiography (TEE), and resting transthoracic echocardiography (TTE), Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation, MAZE procedure, Myocardial sympathetic innervations imaging with or without SPECT, Percutaneous Coronary Intervention (PCI)

- Cosmetic/reconstructive procedures - e.g., rhinoplasty, panniculectomy, lipectomy
- Cranial / facial surgery
- Gastrointestinal Endoscopy (EGD) in adults
- Genetic testing
- Human growth hormone
- Hysterectomy
- Insertion of new pacemaker or replacement/repositioning of previously implanted pacemaker or implantable defibrillator and/or electrodes and related anesthesia; upgrade to implanted pacemaker system; repair of transvenous electrodes
- Insertion of pacemaker pulse generator and related anesthesia
- Intensive outpatient treatment program (IOP)
- Interventional Pain, Epidural Injections, Facet Joint Injections / Medial Branch Blocks, Facet Joint Radiofrequency Nerve Ablation, Sacroiliac Joint Injections, Implanted Spinal Cord Stimulators, Implanted Pain Pumps for Chronic Pain.
- Intraocular implant/shunt
- Large Joint Surgery, Hip / Knee/Shoulder, Arthroplasties (Joint Replacement), Arthroscopies (Joint Scope).
- Locally ablative techniques for treating primary and metastatic liver malignancies
- Lung volume reduction surgery
- Monitored Anesthesia Care
- Nasal / sinus surgery
- Non-emergency CT Scan, CTA, MRA, MRI, MRS, PET Scan CT / PET Scan, SPECT
- Non-emergency Air ambulance
- Nuclear cardiology
- Nuclear technology
- Oral infant formula
- Outpatient electroconvulsive therapy (ECT)
- Partial hospitalization program
- Physical therapy and occupational therapy
- Polysomnography and home sleep study
- Radiation therapy (IMRT, proton beam, brachytherapy, SRS, SBRT)
- Relocation of skin pocket for pacemaker
- Removal of permanent pacemaker pulse generator, pacemaker electrode(s) with or without insertion of new pulse generator
- Requests to have Out-of-Network Services covered under the In-Network level of benefits (Authorized Services)
- Sclerotherapy
- Speech therapy
- Spine Surgery, Cervical / Thoracic / Lumbar Spinal Fusions (Arthodesis), Cervical / Lumbar Spinal Laminectomies, Cervical / Lumbar Spinal Discectomies, Cervical / Lumbar Spinal Disc Arthroplasties (Replacements), Spinal Vertebroplasty / Kyphoplasty.
- Stem cell / bone marrow transplant (with or without myeloablative therapy) and donor leukocyte infusion.
- Therapeutic apheresis
- Transcatheter insertion or replacement of permanent leadless pacemaker, including imaging guidance and device evaluation
- Uvulopalotopharyngoplasty (surgical removal of tissue in the throat to reduce obstructions to the airway. Typically administered to individuals with obstructive sleep apnea).
- Vision therapy

Anthem's Precertification list will change from time to time. You will be notified within a reasonable time period before changes become effective.

How Decisions are Made

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

We use ASAM criteria when determining Medical Necessity and developing utilization review standards for levels of care for Substance Use Disorder Services. "ASAM criteria" means the latest edition of the Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, developed by the American Society of Addiction Medicine.

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 Anthem at 1-855-748-1805.

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 ID Card 1-855-748-1805 for more details.

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent**:** 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 or no previous authorization exists	72 hours from the receipt of the request
Non-urgent: Concurrent / Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and / or electronic. A verbal notice will be followed by a written notice within 2 business days.

Please see the "Claims Payment" section of this Booklet for complete information about the content of our "Notice of a Claim Denial."

To Appeal Anthem's Decision

If you are not satisfied with our decision under this section, you or your authorized representative may appeal it. Please see the "Member Satisfaction Services, Appeals and External Review Procedures" section for complete information including "Time Frames for Internal Appeal Determinations."

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and / or offer an alternate benefit if in our sole discretion, such change furthers the provision of cost effective, value based and / or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider arrangement 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 change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory, on-line pre-certification list or contacting Member Services at 1-855-748-1805.

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

Health Plan Individual Case Management

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

Anthem's 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, Anthem will help you meet your identified health care needs. This is reached through contact and teamwork with you and / or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, Anthem 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, Anthem 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. Anthem will make decisions case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the

alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem to provide the same benefits again to you or to any other Member.

Anthem reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, Anthem will notify you or your authorized representative in writing. Members who disagree with Anthem's decision may utilize the appeal procedure stated in the "Member Satisfaction Services, Appeals and External Review Procedures" section.

What's Covered

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

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

You should also know that many Covered Services can be received in several settings, including a Doctor's office or your home, an Urgent Care Center, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following criteria are met:

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

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

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount. If you do not use the air ambulance Provider we select, except in an emergency, no benefits will be available. Please see the "Schedule of Benefits" for the maximum benefit.

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

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

If you receive Out-of-Network ambulance services, Anthem will pay eligible benefits directly to the Out-of-Network ambulance service Provider or issue a check payable to you and the ambulance service Provider, subject to the terms and conditions of this plan. However, you may be responsible for the difference between the Maximum Allowed Amount and the Provider's charge.

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

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

a) a Doctor's office or clinic;
b) a morgue or funeral home.

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Services

Benefits are available for the treatment of pervasive developmental disorder or autism. To determine the Medical Necessity of services, Anthem may require submission of a treatment plan signed by the Member's Physician, an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology or a licensed psychologist with training in child psychology. Anthem will review the treatment plan no more than once every 6 months unless the Member's Provider changes the treatment plan. Anthem's definition of Medical Necessity is in the "Definitions" section of this Booklet.

Covered Services include:

- Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advance practice registered nurse, licensed psychologist, licensed clinical social worker, or by the Providers identified under the “Mental Health and Substance Use Disorder Services” section of this Booklet.

- Physical, occupational and speech therapy provided by a licensed physical or occupational therapist or by a licensed speech and language pathologist to develop skill or function or to prevent the loss of attained skill or function. As applicable, any visit limits for other physical, speech and occupational therapy, will not apply to physical, occupational or speech therapy to treat pervasive developmental disorder or autism.

- Prescription Drugs, subject to the terms and conditions stated in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section later in this Booklet.

- Applied behavioral analysis that is Medically Necessary to treat pervasive developmental disorder or autism. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

  Except as stated in this "Autism Services” benefit, applied behavioral treatment is not covered.

Behavioral Health Services

Please see “Mental Health and Substance Use Disorder Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when Anthem approves the benefits in advance through Precertification. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage at the In-Network level, services must be Medically Necessary and performed by an Approved In-Network Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain cellular and gene therapy services. Please call us to find out which providers are Approved In-Network Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

In this section you will see some key terms, which are defined below:

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Services to you. The agreement may only cover certain Covered Services or all Covered Services. Approved In-Network Providers may include the following:

- **Blue Distinction Center (BDC) Facility -** Blue Distinction facilities have met or exceeded national quality standards for care delivery of Covered Services.

- **Centers of Medical Excellence (CME) Facility -** Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery of Covered Services.

All Other Providers

Any Provider that is NOT an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Provider for certain cellular or gene therapy services, as well Out-of-Network Providers.

Transportation and Lodging Assistance

If you will need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Services will be provided, we will cover the cost of reasonable and necessary travel costs when you get prior approval. Please see the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell)" benefit for further details on travel coverage, and limits.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

You do not need a Referral from your PCP to be eligible for benefits. The following are Covered Services when furnished by a licensed chiropractor:

1. Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment, and

2. Medically Necessary diagnostic laboratory and x-ray tests.

In addition to the limitations and exclusions stated in the "What's Not Covered" section, the following limitations apply specifically to chiropractic care:

- Wellness care is not covered.
- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a chiropractor or another Physician, and
- Chiropractic care must be provided in accordance with New Hampshire law.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines: 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials, which are exempt from the investigational new drug application.

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

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

All requests for clinical trials services, including services that are not part of approved clinical trials will be reviewed according to Anthem's clinical coverage guidelines, related policies and procedures.

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

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

Court Ordered Services

Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by a Provider, and
- All of the terms of this Booklet are met, including network restrictions, Referral and Precertification rules.

Dental Services

Your Dental Benefits

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

Pretreatment Estimate

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.

Dental Providers

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

For help finding a dentist in your network, log in to www.anthem.com/mydentalvision and go to Find a Doctor. When it asks for the type of doctor, choose dentist. You can also call the Member Services at 1-800-627-0004.

Dental Services For Members Through Age 18

The following dental care services are covered for Members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this plan. Please see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and other benefit limitation information.

Diagnostic and Preventive Services

Oral Exams - Two oral exams are covered within a 12-month period.

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

- Bitewings – 2 series per 12-month period.
- Full mouth (also called complete series) – 1 time per 60-month period.
- Panoramic – 1 time per 60-month period.
- Periapicals and occlusals films are also covered.
- Cephalometric
- 2D oral / facial photographic image obtained intra-orally or extraorally.

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

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

Topical Application of Fluoride With or Without Fluoride Varnish - Covered 2 times per 12-month period.

Sealants - Covered 1 time per 36-month period.

Preventive Resin Restorations - Covered 1 time per tooth every 36-month period.

Space Maintainers and Recement Space Maintainers

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

Diagnostic Casts

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 and coinsurance.

Sedative Fillings

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 (please see Diagnostic and Preventive Services above) is covered 4 times per 12-month period.

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

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.

Pre-fabricated Stainless Steel Crowns - Covered 1 time per 60-month period for primary teeth. These crowns are covered 1 time per 60-month period for permanent teeth through the age of 14. Prefabricated resin and stainless steel crowns with resin or esthetic coating are not covered.

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

Recement cast or prefabricated post and core

Pin Retention

Therapeutic Drug Injection

Partial pulpotomy for apexogenesis

Basic Extractions

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

Endodontic Services

- Pulpal therapy for anterior and posterior primary teeth
- Therapeutic pulpotomy

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

- Root canal therapy
- Root canal retreatment

All of the above endodontic services are limited to once per tooth per lifetime.

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation per root
- Hemisection
- Surgical repair of root resorption

Periodontal Services

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. The following services are considered complex surgical periodontal services:

- 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
- Autogenous and Non-autogenous connective tissue graft

Crown Lengthening – Covered once per lifetime.

Oral Surgery Services

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

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

Other Complex Surgical Procedures

- Alveoloplasty

- Removal of exostosis – per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures:

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

Adjunctive General Services

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.

Administration of general anesthesia by a licensed dentist may be covered when given with a dental service in a dental office setting on a member who:

- has been determined by a Physician to have a dental condition of such complexity that the child must get general anesthesia to have their treatment done; or
- is a member who has an exceptional medical circumstance or disability which places the member at serious risk.

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're responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Onlays or Permanent Crowns - Covered 1 time per 60-month period. 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 metallic onlay or a predominantly base metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable Deductible and Coinsurance.

Inlay, Onlay, Crown and Veneer Repair - Covered 1 time per 36-month period. The narrative from your treating dentist must support the procedure.

Implant Crowns - Please see the implant procedures description under "Prosthodontic Services."

Restorative Cast Post and Core Build Up - Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60-month period. 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 1 time per tooth every 60-month period.

Resin infiltration for incipient smooth surface lesions.

Occlusal Guards - Covered 1 time per 12-month period for members age 13 through 18.

Prosthodontic Services

Dentures and Partial Dentures (removable prosthodontic services) - Covered 1 time per 60-month period 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.

Overdentures for Dentures and Partial Dentures - Overdentures will be paid up to the same Maximum Allowed Amount for a denture or a partial denture. You are responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Bridges (fixed prosthodontic services) - Covered 1 time per 60-month period 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 more than 3 teeth missing 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 1 time per 36-month period as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months have passed from the initial placement of the appliance.

Denture and Partial Denture Repairs

Replacement of Broken Clasps

Replacement of Broken Artificial Teeth

Denture Adjustments

Partial and Bridge Adjustments

Recement Bridge (fixed prosthetic)

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

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

dentist should send it to us so we can help you understand how much is covered by your benefits.

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

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

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

- Pre-Orthodontic Treatment Exams. Periodic visits with your dental provider to establish when orthodontic treatment should begin.
- 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.
- 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 plan.

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 plan ends.

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

What Orthodontic Care Does NOT Include

The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately - these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately - these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.

- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this plan.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Dental Services For Members Age 19 and Older

The following dental care services are covered for Members age 19 and older. All covered services are subject to the terms, limitations, and exclusions of this plan. Please see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and other benefit limitation information.

Diagnostic and Preventive Services

Periodic, Comprehensive and Periodontal Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per 12-month period.

> NOTE: Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per 12-month period limitation. Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per 12-month period limitation.

Limited, Detailed / Extensive and Problem Focused Evaluations - Covered 2 times per 12-month period.

Radiographs (X-rays)

- Bitewings - 1 series per 12-month period.
- Full Mouth (Complete Series) or Panoramic - Once per 60-month period.
- Periapical(s) - 4 single x-rays per 12-month period.
- Occlusal - 2 series per 12-month period.

Dental Cleaning (Prophylaxis) - is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure, periodontal maintenance, Scaling in the Presence of Moderate or Severe Gingival Inflammation or Full Mouth Debridement (Please see “Periodontal Services” below) are covered 2 times per 12-month period.

Basic Restorative Services

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

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

Composite (white) Resin Restorations

- Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). You must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment plus any Deductible and / or Coinsurance.

Benefits for amalgam or composite restorations will be limited to one service per tooth surface per 24-month period.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth

- Extraction of erupted tooth or exposed root

Brush Biopsy - Covered once per 12-month period.

Consultations - Covered once per 12-month period.

Pin-retention - Covered once per 84-month period.

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy
- Therapeutic Pulpotomy

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

All of the above endodontic services are limited to 1 time per tooth, per lifetime.

Pulp Cap - Covered 1 time per tooth (primary or permanent) per lifetime.

Surgical Endodontics

- Apicoectomy – Covered 1 time per tooth per lifetime
- Retrograde Filling - Covered
- Root amputation - Covered
- Hemisection – Covered 1 time per tooth per lifetime
- Apexification – Covered 1 time per tooth per lifetime

Periodontal Services

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

Benefits for any combination of this procedure and dental cleanings (please see “Diagnostic and Preventive Services” section), Full Mouth Debridement and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered 4 times per 12-month period.

Scaling in the Presence of Moderate or Severe Gingival Inflammation - Scaling in the Presence of Moderate or Severe Gingival Inflammation is a procedure to remove plaque, tartar and calculus when there is moderate or severe gum inflammation.

LIMITATION: Any combination of this procedure, dental cleanings (please see Diagnostic and Preventive section), Periodontal Maintenance and Full Mouth Debridement is covered 2 times per 12-month period.

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

- **Periodontal scaling & root planing** is covered 1 time per 24-month period if the tooth has a pocket depth of 4 millimeters or greater or if the tooth shows demonstrable radiographic evidence of bone loss.
- **Full mouth debridement** – any combination of this procedure, Dental cleanings (please see Diagnostic and Preventive section), Periodontal Maintenance and Scaling in the Presence of Moderate or Severe Gingival Inflammation is covered once per lifetime.

Chemotherapeutic Agents - Covered 1 time per 12-month period.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. All surgical periodontal services are covered on natural teeth only. Surgical periodontal services are denied when performed in conjunction with implants, extractions, ridge augmentation and periradicular surgery services. The following services are considered complex surgical periodontal services:

- Gingivectomy / gingivoplasty;
- Gingival flap;
- Osseous surgery;
- Bone replacement graft;

LIMITATION: Any 1 or a combination of the above services may be performed 1 time per 36-month period. Complex surgical periodontal service is a benefit covered only if the pocket depth of the tooth is 5 millimeters or greater.

Additional Complex Surgical Periodontal Care

- Pedicle soft tissue graft;
- Apically positioned flap;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal / proximal wedge - Covered on natural teeth only; and
- Guided Tissue Regeneration

The additional complex surgical periodontal services listed above are covered once per tooth, per 36-month period.

Crown Lengthening

Oral Surgery Services

Complex Surgical Extractions

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

Surgical removals of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures - Complex Oral Surgery includes surgical procedures that involve flap development with the removal and replacement of diseased hard and soft tissues of the oral cavity.

- Oroantral fistula closure
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Biopsy of oral tissue
- Transseptal fiberotomy
- Alveoloplasty
- Vestibuloplasty
- Excision of lesion or tumor
- Removal of nonodontogenic or odotogenic cyst or tumor
- Removal of exostosis-per site

- Partial ostectomy
- Incision & drainage of abscess
- Surgical reduction of osseous tuberosity
- Surgical reduction of fibrous tuberosity
- Frenulectomy (Frenectomy or Frenotomy)

Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical service.

Major Restorative Services

Gold foil restorations - The Plan will cover an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

You must pay the difference in cost between the Maximum Allowed Amount for the Covered Services and optional treatment plus any Deductible and / or Coinsurance that applies. Covered 1 time per 24-month period.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible and / or Coinsurance that applies.

Pre-fabricated Stainless Steel Crown – Covered 1 time per 84-month period.

If a prefabricated resin crown is performed, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and optional treatment, plus any Deductible and / or Coinsurance that applies.

Onlays and / or Permanent Crowns - Covered 1 time per 84-month period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

We will pay up to the Maximum Allowed Amount for a predominately base metal onlay and / or crown. If a porcelain or noble metal onlay is performed to restore a tooth, you must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment, plus any Deductible and / or Coinsurance that applies.

Implant Crowns – Please see “Prosthodontic Services.”

Recement Inlay, Onlay, and Crowns - Covered 1 time per 12-month period. Covered 6 months after initial placement.

Crown, Inlay, Onlay and Veneer Repair - Covered 1 time per 12-month period. Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered one time per 84-month period when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Occlusal Guard – Covered 1 time per 24-month period.

Veneers – Covered 1 time per 84-month period.

Prosthodontic Services

Tissue Conditioning - Covered 1 time per 24-month period.

Reline and Rebase - Covered 1 time per 24-month period when:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 time per 12-month period when:

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

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

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

Partial and Bridge Adjustments - Covered 2 times per 12-month period when:

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

Removable Prosthodontic Services (Dentures and Partials) - Covered 1 time per 84-month period:

- If 84 months have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 84-month period.

- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 84 months;
- If 84 months have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. Benefits shall be limited to the same surfaces and allowances for a base metal restoration. If a porcelain or noble metal restoration is performed to restore a tooth, we will pay up to the Maximum Allowed Amount for a predominantly base metal restoration. You must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and the optional treatment, plus any Deductible and / or Coinsurance that applies.

Recement Fixed Prosthetic - Covered 1 time per 12-month period.

Implant Supported Fixed and Removable Prosthetic (Crowns, Bridges, Partials, and Dentures) - A restoration that is retained, supported and stabilized by an implant. Implants and related services are not covered.

LIMITATION: This procedure receives an optional treatment benefit equal to the least expensive professionally-acceptable treatment. The additional fee is your responsibility. For example, a single crown to restore one open space will be given the benefit of a fixed partial denture pontic (one unit).

Dental Coverage Appeals

Please see the “Member Satisfaction Services, Appeals and External Review Procedures” section for complete information about how to submit an appeal regarding the Dental coverage stated in this part of the Booklet.

Enhanced Benefits for Members Enrolled in the Anthem Care Management program

Enhanced dental benefits are available for any member enrolled in the Anthem Care Management program who is in active management with an Anthem Case Manager for the following conditions:

- Cancer with chemotherapy;
- Head and neck cancer with chemotherapy and / or radiation;
- Solid organ transplant;
- Heart disease;
- Diabetes;
- Pregnancy;
- Stroke;
- Kidney failure/dialysis;
- Suppressed Immune System (HIV).

The following grid identifies and explains how your enhanced benefits will be administered:

Anthem Whole Health Connection								
	Periodontal Maintenance[1]	Periodontal Scaling and Root planing[2]	Periodontal & Oral Evaluations[3]	Routine Cleaning[4]	Palliative Treatment[5]	Fluoride[6]	Sealants[7]	Full Mouth Debridement[8]
Diabetes	√	√	√	√	√			√
Heart Disease	√	√	√	√	√			√
Pregnancy	√	√	√	√	√	√	√	√
Stroke	√	√	√	√	√			√
Kidney Failure/Dialysis	√	√	√	√	√	√	√	√
Head and Neck Cancer w/ Chemo/ Radiation	√	√	√	√	√	√	√	√
Cancers (with chemo)	√	√	√	√	√	√	√	√
Solid Organ Transplant	√	√	√	√	√	√	√	√
Suppressed Immune System (HIV)	√	√	√	√	√			√

[1]Covered at standard frequency

[2]One additional scaling & root planing procedure per quadrant

[3]One additional oral evaluation

[4]One additional routine cleaning; frequency shared with periodontal maintenance

[5]Covered at standard frequency

[6]Removes age limits and provides one additional fluoride treatment

[7]Removes age limits

[8]Covered at standard frequency

Plan provides 100% coverage for qualified benefits and additional frequencies noted regardless of annual maximum/Deductible in conjunction with qualified medical conditions.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

1) Evaluation
2) Dental x-rays
3) Extractions, including surgical extractions
4) Anesthesia

Dental Treatment of Accidental Injury

Benefits are available for dental work that is Medically Necessary due to an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is authorized by Anthem. Medically Necessary treatment due to injury to the jaw and oral structures other than teeth shall also be covered when authorized by Anthem.

Cost sharing amounts for emergency treatment are shown on your Schedule of Benefits under "Emergency Room Services" and "Inpatient Services." No Benefits are available for treatment if you damage your teeth or appliances as a result of biting or chewing unless the biting or chewing results from a medical or mental condition. No Benefits are available for treatment to repair, restore or replace items such as fillings, crowns, caps or appliances that are damaged as a result of an accident.

In addition to treatment of accidental injury to sound natural teeth and gums as described above, benefits are available for dental work needed to treat injuries to the jaw, mouth, or face as a result of an accident. Coverage shall be subject to the same terms, conditions and cost sharing amounts as applicable to other similar medical or surgical services covered in this Booklet.

Hospital Facility and Anesthesia Services for Certain Individuals Undergoing Dental Procedures

Benefits are available for hospital facility charges (inpatient or outpatient), surgical day care facility charges and general anesthesia furnished by a licensed anesthesiologist or anesthetist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia benefits are:

- Children whose dental condition is so complex that the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's Physician must determine in advance that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition. Anthem must approve the care in advance.

- Members who have exceptional medical circumstances or a developmental disability. The exceptional medical circumstance or the developmental disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Member's Physician and Anthem must approve the services in advance.

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

Diabetes Management Programs

Benefits are available for outpatient diabetes self-management training and educational services. Training and educational services include, but are not limited to, medical nutrition therapy furnished by a Provider with expertise in diabetes management. Other Covered Services are:

- Individual counseling visits,
- Group education programs and fees required to enroll in an approved group education program, and
- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" later in this section for information about coverage for external insulin pumps.

In addition to the limitations and exclusions listed in the "What's Not Covered" section, the following limitations apply specifically to diabetes management services:

- Covered Services must be furnished by a certified, registered or licensed health care expert in diabetes management. Otherwise, no benefits are available.
- Diabetic supplies, equipment, insulin and oral agents are not covered under this subsection. Please see the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section for information about benefits for insulin, diabetic medications and diabetic equipment or supplies furnished by a Pharmacy. Please see "Medical and Surgical Supplies" under "Durable Medical Equipment (DME), Medical Devices, and Supplies" later in this section for information about diabetic equipment or supplies furnished by a medical equipment or supplies Provider.

Except for diabetes management services and other screenings and services such as nutrition counseling required by law under the "Preventive Care" benefit, no benefits are available for non-surgical services, treatments, procedures or programs for weight or appetite control, weight loss, weight management or control of obesity. However, benefits are available for Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see "Surgery for conditions caused by obesity" under "Surgery" later in this section.

No benefits are available for weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Booklet. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

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

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. (Routine hearing and vision screenings are covered under "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.

Dialysis

Please see "Therapy Services" later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

Durable Medical Equipment (DME) and Medical Devices

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

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

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

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

Oxygen and equipment for its administration are also Covered Services.

Hearing aids, including FDA-approved over-the-counter hearing aids, are covered as stated in "Hearing Services" later in this section.

Orthotics

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

Orthotics may only be replaced once per year, when Medically Necessary. However, additional replacements will be allowed:

- For Members when needed as a result of rapid growth, or
- For Members of any age, when an appliance is damaged and cannot be repaired.

Foot orthotics (orthopedic shoes or footwear or support items) are not covered unless used for an illness affecting the lower limbs, such as severe diabetes.

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:

1) Artificial limbs and accessories. Artificial limbs are prosthetic devices that replace, in whole or in part, an arm or leg.
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis).
6) Scalp hair prosthesis. A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and / or who have permanent hair loss as a result of injury.

   Except as described above, no benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no benefits are available for temporary hair loss. No benefits are available for male pattern baldness.

7) Bone-anchored hearing aids and cochlear implants.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are most often used only once, and are purchased (not rented). Covered supplies include syringes and 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 supplies and equipment are covered for the treatment of diabetes. Covered diabetic supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this subsection when diabetic supplies are purchased from a licensed medical equipment or medical supplies Provider. Please see the "Prescription Drug Benefit at a

Retail or Home Delivery (Mail Order) Pharmacy" section for information about coverage for diabetic supplies and equipment furnished by a Pharmacy for take-home use.

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

- Needed to sustain life; and is
- Medically Necessary, as defined in the "Definitions" section of this Booklet, represents the best medical practice; and is
- The least restrictive means for meeting your medical needs.

Otherwise, no benefits are available.

Except as provided in this Booklet or as required by law, no benefits are available for dietary supplements. No benefits are available for those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Blood and Blood Products

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

Emergency Care Services

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

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered. For non-Emergency Care please use the closest In-Network Urgent Care Center or your Primary Care Physician.**

Emergency (Emergency Medical Condition)

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

Emergency Care

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

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. For Surprise Billing claims the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and / or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your cost shares will be based on the Recognized Allowed Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls Anthem as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized is not Emergency Care.
Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details on how this will impact your benefits.

Habilitative Services

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

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

Hearing Services

Diagnosis and Treatment of Ear Disease or Injury - Benefits are available for Inpatient and outpatient services to diagnose and treat ear disease or injury. Benefits are also available for the professional services of a hearing care professional or hearing instrument dispenser for the fitting, dispensing, servicing, or sale of hearing aids as stated in "Hearing Aids," (below).

Certain hearing screenings required by Federal law are covered under the "Preventive Care" benefit. No benefits are available for routine hearing exams for Members with no current symptoms or prior history of a hearing illness, injury or the need for hearing correction.

Hearing Aids

"Hearing aid" means any instrument or device, including bone-anchored hearing aids and cochlear implants, designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including batteries, cords, and ear molds.

A hearing aid, including FDA-approved over-the-counter hearing aids, must be prescribed, fitted, serviced and dispensed by a hearing professional. A hearing care professional is a person who is a licensed audiologist, a licensed hearing instrument dispenser or a licensed Physician. Otherwise, no benefits are available.

A hearing instrument dispenser is a person who is a licensed hearing care professional that engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing aids or the testing for means of hearing aid selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing

aids. The “practice of fitting, dispensing, servicing, or sale of hearing aids” means the measurement of human hearing with an audiometer, calibrated to the current American National Standard Institute standards for the purpose of making selections, recommendations, adoptions, services, or sales of hearing aids including the making of ear molds as a part of the hearing aid.

Hearing aids furnished by a licensed durable medical equipment Provider are subject to the cost sharing amounts shown on your Schedule of Benefits for durable medical equipment and are subject to the terms and conditions of “Durable Medical Equipment (DME), Medical Devices, and Supplies” earlier in this section.

When hearing aids are furnished by a Provider who is not a licensed durable medical equipment Provider, Covered Services are subject to the same cost sharing amounts shown on your Schedule of Benefits for similar supplies furnished in an office or other outpatient setting.

Charges for individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are not covered.

Benefits for hearing aids, including FDA-approved over-the-counter hearing aids, are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount for the least expensive service that meets your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowed Amount for the least expensive service and the charge for the more expensive service.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care 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:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and / or family / caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise, no benefits are available. For example, if you are confined to bed rest or your activities of daily living are otherwise restricted by order of your Physician, prenatal and / or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, your Physician will consult with Anthem’s case manager.
- Therapy Services (except for chiropractic and osteopathic Manipulation Therapy which will not be covered when given in the home).
- Medical supplies
- Durable medical equipment

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

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the "Inpatient Services" section below.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

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

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

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

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

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

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

To be eligible for benefits, transplants must be approved *in advance* by your Doctor and by Anthem's Precertification. You and the organ donor must receive services from an In-Network Provider or other Provider as determined by Anthem. Otherwise, no benefits are available. Out-of-Network benefits are not applicable.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

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

Prior Approval and Precertification

To maximize your benefits, you should call Anthem's Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and / or work-up for a transplant. Anthem will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call Member Services at 1-855-748-1805 and ask for the transplant coordinator. Even when Anthem gives a Prior Approval for the Covered Transplant Procedure, you or your Provider must call Anthem's 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 Anthem must agree that the transplant is Medically Necessary. Anthem's definition of Medical Necessity is stated in the "Definitions" section of this Booklet.

Your Doctor should send a written request for Precertification to Anthem as soon as possible to start this process. If Anthem notifies you that the transplant is not approved and you decide to receive the services, no benefits will be available.

If you or your Doctor do not contact Anthem for Precertification as required and Anthem later determines that the transplant was not Medically Necessary, no benefits will be available.

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

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.

- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.

- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

- HLA testing is covered for Members who undergo the testing for the purposes of participating in the National Marrow Donor Program, provided that:

    - The Member meets the criteria for testing established by the National Marrow Donor program,
    - The Member completes and signs an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program,

- The Member acknowledges a willingness to be a bone marrow donor if a suitable match is found, and
- The screening is furnished by a Provider acting within the scope of the Provider's license.

An HLA test is a human leukocyte antigen laboratory test, also referred to as a histocompatibility locus antigen laboratory test. Benefits for HLA testing are limited to the Maximum Allowed Amount as allowed by law. New Hampshire law prohibits Providers to bill, charge, collect a deposit from, seek payment for or reimbursement from, or have recourse against a Member for any portion of the HLA laboratory fee expenses.

Except as described under "Ambulance Services" earlier in this section, no benefits are available for transportation for transplant recipients or donors. No benefits are available for mileage, lodging, meals or other travel costs.

Transportation and Lodging

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

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

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

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

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Care for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include care 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.
- Professional charges to read diagnostic tests such as imaging, pathology reports, and cardiology.

*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 Health 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 Benefits under "Inpatient Services" will apply.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed as a result of a miscarriage. Once we know of the pregnancy, we will provide the Member with benefit information in writing regarding prenatal, maternity and postpartum services, including but not limited to prenatal visits, diagnostic tests, prenatal education, hospital length of stay, postpartum care, homemaker services, and contraceptive counseling and referrals. Maternity services incurred prior to your Effective Date are not covered except where it may be Medically Necessary for prenatal homemaker services when the woman is confined to bed rest or where her doctor has ordered her daily activities to be restricted. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home, including the services of a New Hampshire Certified 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, including physical assessment of mother and infant (i.e., lab tests and ultrasounds) may be subject to cost shares; and
- Fetal screenings, which are genetic and / or chromosomal tests of the fetus, as allowed by Anthem.

Routine prenatal office visits, and other preventive prenatal and postnatal care and screenings are covered under "Preventive Care" as required by law.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services paid at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a request form and send it to us. Call Member Services at 1-855-748-1805 for a request form. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note about Maternity Admissions: Under federal law, Anthem 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, Anthem may not require a Provider to get authorization from Anthem before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

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

Contraceptive Services

Please see "Preventive Care" (below in this section) for details about contraceptive services for women.

Sterilization Services

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

Abortion Services

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

Infertility Services

Covered Services include Medically Necessary diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, as well as Prescription Drugs. The Medical Necessity of Covered Services is based upon guidelines established by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology.

Medically Necessary Covered Services, as recognized by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology as a cause of infertility, will include, but will not be limited to:

- Intracervical or Intrauterine Artificial Insemination (AI).
- Assisted Reproductive Technology (ART) such as, In-vitro fertilization and Embryo Transfer (IVF-ET), Gamete Intra-fallopian Transfer (GIFT), or Zygote Intra-fallopian Transfer (ZIFT).
- Cryopreservation of embryos, eggs, sperm and reproductive material that is not Experimental / Investigational, when provided as part of an active, covered artificial insemination procedure or ART cycle.
- Preserve fertility when a Member is expected to undergo surgery, radiation, chemotherapy or other medical treatment: Storage of cryopreservation material shall begin at the time of the cryopreservation and will continue provided the Member continues to be covered under this plan but only until the next plan renewal.

Precertification must be obtained for Covered Services designed to treat infertility.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that Anthem must cover per New Hampshire law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and rehabilitation. For treatment of Substance Use Disorders, benefits include clinical stabilization services and short-term Inpatient withdrawal management.

- **Emergency Room Boarding** - Following the completion of an involuntary admission certificate for a patient, Anthem will cover board and care for the patient waiting in an Emergency Department of an acute care hospital located in the state of New Hampshire for each day the Member is waiting for admission for psychiatric treatment to the New Hampshire State Hospital, a community-based designated receiving facility, or a voluntary admission, for up to 21 consecutive days or more until discharged.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

  - Observation and assessment by a Physician weekly or more often,
  - Rehabilitation and therapy.

- **Outpatient Services** including office visits, Telemedicine, therapy and treatment, Partial Hospitalization / Day Treatment Programs, Intensive Outpatient Programs and when available in your area, Intensive In-Home Behavioral Health Services. Covered Services include detoxification and rehabilitation services. Benefits are available for psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates.

  Outpatient visits are covered for pervasive developmental disorder or autism. Please see “Autism Services” earlier in this section for important information about other services for pervasive developmental disorder or autism, including applied behavioral analysis.

- **Virtual Visit**s as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" later in this section.

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

- Community Mental Health Center
- For the treatment of pervasive developmental disorder or autism - An individual who is professionally certified by a national board of behavior analysts or who is under the supervision of a person professionally certified by a national board of behavior analysts.
- Licensed alcohol and drug abuse counselor
- Licensed clinical mental health counselor (L.P.C.)
- Licensed clinical social worker (L.C.S.W.)
- Licensed marriage and family therapist (L.M.F.T.)
- Licensed pastoral psychotherapist
- Licensed psychologist
- Licensed, psychiatrist-supervised Physician Assistants
- Neuropsychologist
- Partial Hospitalization or Intensive Outpatient Treatment Program (day treatment program)
- Private or Public Hospital
- Psychiatric Advanced Practice Registered Nurse
- Psychiatrist
- Residential Psychiatric Treatment Facility
- Short Term General Hospital
- Substance Use Disorder Treatment Provider
- Any of the above unlicensed Providers who possesses at least a master's level education and is permitted by the respective New Hampshire professional licensing law to practice under the supervision of a qualified New Hampshire licensee and who is actively pursuing professional licensure.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

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

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

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

Urgent Care as described in "Urgent Care Services" later in this section.

Virtual Visits as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

Prescription Drugs Administered in the Office, including travel and rabies vaccines that are not covered under the "Preventive Care" benefit later in this section.

Prescription Contraceptive Drugs and Devices Administered in the Office - Please see "Preventive Care" below in this section for information about contraceptive services for women.

Orthotics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by Anthem.

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

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

Physical Rehabilitation Facility

When you require Inpatient skilled physical rehabilitation in a Facility that is state authorized and licensed to provide physical rehabilitation services and which provides short-term active professional care.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

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

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:

    a. Breast cancer, including mammograms and Tomosynthesis (3-D mammograms),
    b. Cervical cancer screenings including pap smears,
    c. Colorectal cancer, including routine colonoscopy screening for colorectal cancer, fecal occult blood test, barium enema, flexible sigmoidoscopy and related prep kit,
    d. Lead screening,
    e. Routine physical exams for babies, children and adults, including an annual gynecological exam,
    f. High blood pressure,
    g. Type 2 Diabetes Mellitus,
    h. Cholesterol,
    i. Child and adult obesity.

2. Immunizations for babies, 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, including lead screening.

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. Contraceptive services for women. As required by law, contraceptive services are covered at no cost for women with reproductive capacity. This benefit includes at least one form of contraception in each of the contraceptive methods identified for women by the U.S. Food and Drug Administration (FDA). FDA-identified methods include, but are not limited to barrier methods, hormonal methods, implanted devices and sterilization procedures. Education and counseling, Outpatient consultations, examinations and medical services related to the use of contraceptive methods are also covered at no cost under this section.

        FDA-approved contraceptive Prescription Drugs and devices for women are covered at no cost under this section. This benefit includes Generic oral contraceptives, as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine 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 $0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling Member Services at the number listed on the back of your ID Card **1-855-748-1805**. 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. Otherwise, Brand Drugs and devices are covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section in this Booklet.

        Over-the-counter contraceptive methods identified for women by the FDA are covered at no cost under this section when obtained with a Prescription from your Doctor.

        When prescribed by your Doctor, Anthem will dispense contraceptives in a quantity intended to last for 12 months.

    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

c. Gestational diabetes screening.

d. Annual gynecological exams.

5. Office visits for routine prenatal care.

6. Nutrition counseling, including but not limited to nutrition counseling for treatment of eating disorders.

7. Preventive care services for smoking cessation and tobacco cessation for adults and adolescents as recommended by the United States Preventive Services Task Force including:

   a. Counseling

   b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy.

   c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

8. 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:

   a. Aspirin

   b. Folic acid supplement

   c. Bowel preparations

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

You may call Member Services 1-855-748-1805 for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov and http://www.cdc.gov/vaccines/acip/index.html.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. Out-of-Network cost shares will apply when services are provided by an Out-of-Network provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies"). Details on those guidelines can be found on the IRS's website at the following link:

https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Health care services that help you keep, get back or improve skills and functioning for daily living that have been lost or impaired because you were 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 such as in a Hospital, free-standing Facility, Skilled Nursing Facility, an outpatient day rehabilitation program or in an office.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist. To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

Preventive screenings, counseling and other Preventive Care services for tobacco use and tobacco cessation are covered as required by law under the “Preventive Care” benefit above in this section and in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section. Smoking cessation programs are not covered.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

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

Bariatric Surgery for Conditions Caused by Obesity

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

Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of this Booklet, even if the surgery, service or program is ordered by your Physician or performed or ordered by another Provider. This exclusion applies even if the surgery, service or program meets Anthem's definition of Medical Necessity. Except as stated in this subsection, no benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

Please see "Diabetes Management Programs," "Preventive Care" and the "Outpatient Services" benefit under "Mental Health and Substance Use Disorder Services" in this section for information about covered non-surgical services for weight management.

No benefits are available for weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Booklet. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Oral Surgery

Benefits are available for Medically Necessary oral surgery, including the following:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and / or lower jaw bone and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services (All Members / All Ages)" section.
- Surgical services as described in the "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
- Surgical procedures that are Medically Necessary to correct disorders caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations.
- Reconstructive surgery as described below.

Except as stated in this subsection and in the "Dental Services," "Reconstructive Surgery" and "Temporomandibular Joint (TMJ) and Craniomandibular Joint Services" subsections, no benefits are available for tooth extraction, surgery for impacted teeth or any other care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, an earlier treatment, and to improve bodily function or symptoms or to create a normal appearance.

Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner chosen by the patient and the Physician. Benefits are also available for prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Telemedicine

Please see the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below.

Physical, Speech and Occupational Therapy

Covered physical, speech and occupational therapy services may be rehabilitative or habilitative.

Rehabilitative therapies help you to get back or improve health, skills and functioning that have been lost or impaired because you were sick, hurt or disabled. Examples include care by physical means to ease pain, restore health, and / or to avoid disability after an illness, injury, or loss of an arm or a leg. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time.

Habilitative therapies help Members to 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 and therapies for Members with disabilities.

- **Physical therapy -** Services furnished by a licensed physical therapist. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.
- **Speech therapy and speech-language pathology (SLP) services -** Services furnished by a licensed speech therapist. It includes assessment of and therapy for speech, language, and swallowing disorders or impairments.
- **Post-cochlear implant aural therapy -** Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** - Services furnished by a licensed occupational therapist to restore or maintain 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 care for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Osteopathic Manipulation therapy** - Osteopathic manipulation is therapy to treat problems of the bones, joints, and the back. Osteopathic therapy focuses on the joints and surrounding muscles, tendons and ligaments.
- **Acupuncture -** Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Early Childhood Intervention Services

Early childhood intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with an identified developmental disability and / or delay. Covered Services include Medically Necessary services furnished by licensed occupational and physical therapists, licensed speech-language pathologists and licensed clinical social workers.

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. Please see the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis -** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy -** Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Please 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.
- **Cognitive rehabilitation therapy –** Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy -** Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy -** Includes the use of dry or moist gases in the lungs, non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Also, please see "Autism Services" and "Chiropractic Services" earlier in this section.

Transplant Services

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

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem means a medical or mental health condition or symptomatic illness of a covered person that if not treated within 48 hours presents a risk of serious harm.

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

Virtual Visits (Telemedicine Telehealth Visits) are covered for Medically Necessary physical medicine and mental health visits that are appropriately provided through interactive electronic communications and information technology. Services include the use of live (synchronous) secure videoconferencing, chat, voice or secure instant messaging through our mobile app, as well as the use of audio, video or other electronic media for the purpose of diagnosis, consultation, care management and self-management or treatment. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

"Medical Chat" means Covered Services accessed through our mobile app with a Provider via text message or chat for limited medical care.

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

Telemedicine does not include the use of facsimile, texting (outside of our mobile app) or non-secure instant messaging.

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.

Except as stated above, no Benefits are available for Virtual Visits (Telemedicine / Telehealth Visits).

Vision Services for Members Through Age 18

The vision benefits described in this section only apply to Members through age 18. Benefits will continue through the end of the month that the Member turns 19.

To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call Member Services at 1-866-723-0515. Please see the Schedule of Benefits to see your Deductible, Coinsurance, Copayment and other benefit limitations.

Routine Eye Exam

This Plan covers a complete eye exam with dilation, as needed. The exam is used to check all aspects of your vision, including the structure of the eyes and how well they work together.

Eyeglass Lenses

Covered standard eyeglass lenses include standard plastic (CR39) lenses up to 55mm in 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. Please see the Schedule of Benefits for the list of 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 benefit period, you can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given benefit period. Your Blue View Vision provider will have a collection of contact lenses for you to choose from. They can tell you which contacts are included at no extra charge and which ones will cost you more.

- Elective contact lenses – these are contacts that you choose for comfort or appearance.

- Non-Elective Contact Lenses - these are contacts that are prescribed for certain eye conditions:
    - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    - High Ametropia exceeding -12D or +9D in spherical equivalent.
    - Anisometropia of 3D or more.
    - Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not pay for Non-Elective Contact Lenses for any Member that has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices, and provide training instruction to maximum the Member's vision.

Vision Coverage Appeals

Please see the "Member Satisfaction Services, Appeals and External Review Procedures" section for complete information about how to submit an appeal regarding your vision coverage as stated in this part of the Booklet.

Vision Services for Members Age 19 and Older

To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding Blue View Vision Provider, please call Customer Services at 1-866-723-0515. Please see the Schedule of Benefits to see your Deductible, Coinsurance, Copayment and other benefit limitations.

Routine Eye Exam

This Plan covers a complete routine eye exam with dilation, as needed. The exam is used to check all aspects of your vision. An eye exam does not include a contact lens fitting fee.

Eyeglass Lenses

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in single vision, bifocal, or trifocal (FT 25-28). Factory scratch coating is included at no extra cost when you get lenses from a Blue View Vision provider.

Frames

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

Contact Lenses

Each benefit period, you can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given benefit period.

- Elective Contact Lenses – these are contacts you choose for comfort or appearance.

- Non-Elective Contact Lenses – these are contacts that are prescribed for certain eye conditions:

    - Keratoconus when your vision 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.
- When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

Vision Coverage Appeals

Please see the "Member Satisfaction Services, Appeals and External Review Procedures" section for complete information about how to submit an appeal regarding your vision coverage as stated in this part of the Booklet.

Vision Services (All Members / All Ages)

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

Benefits do not include glasses or contact lenses except as stated above in "Vision Services For Members Through Age 18", "Vision Services for Members Age 19 and Older" and in "Prosthetics" under the "Durable Medical Equipment (DME), Medical Devices, and Supplies" benefit earlier in this section. Benefits for routine vision exams are covered only as stated above.

Prescription Drugs Administered by a Medical Provider

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

Please see "Preventive Care" in the "What's Covered" section for more information about contraceptive Prescription Drugs and devices for women that must be administered by a Provider.

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 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 which requires that one Drug, Drug regimen, or treatment must 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.

Covered Prescription Drugs

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

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

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

For a list of Prescription Drugs that need precertification, please call Member Services at 1-855-748-1805. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

If precertification is denied you have the right to file an appeal as outlined in the "Member Satisfaction Services, Appeals and External Review Procedures" section of this Booklet.

Designated Pharmacy Provider

Anthem, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program. The toll-free Member Services phone number is 1-855-748-1805.

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

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

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

You can get the list of the Prescription Drugs covered under this section by calling Member Services at 1-855-748-1805 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 Member Services at the phone number on the back of your ID Card 1-855-748-1805.

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

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

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

Prescription Drug Benefits

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

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

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

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

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at 1-855-748-1805 or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

If prior authorization is denied you have the right to file an appeal as outlined in the "Member Satisfaction Services, Appeals and External Review Procedures" section of this Booklet.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy including Drugs prescribed for the treatment of pervasive developmental disorder or autism.
- 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 and prescribed oral diabetes medications.
- Self-administered human growth hormones to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.
- Self-administered contraceptive Drugs and devices, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, diaphragms, cervical caps and contraceptive rings. Benefits are available for the emergency oral contraceptive "morning after pill," for female Members. Please see "Preventive Care" in the "What's Covered" section for more information about contraceptive Prescription Drugs and devices for women. As required by law, Generic contraceptives for women are Preventive Care Services and are covered in full when furnished by an In-Network Pharmacy. Brand Drugs and devices will be covered as a Preventive Care benefit only if your Doctor determines that a Brand is medically necessary and writes, "Dispense as Written" or "Do not Substitute" on your Prescription. As required by law, over-the-counter contraceptive products for women are Preventive Care Services and are covered in full when purchased at an In-Network Pharmacy with a Prescription from your Doctor.
- Vitamin supplements that require a prescription by law.
- Flu Shots (including administration). These will be covered in full under the "Preventive Care" benefit in the "What's Covered" section when furnished by an In-Network Provider.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered in full under the "Preventive Care" benefit in the "What's Covered" section when furnished by an In-Network Pharmacy.
- FDA-approved smoking cessation products for tobacco cessation for adults and adolescents, including over-the-counter nicotine replacement products, when obtained with a Prescription. These products will be covered in full under the "Preventive Care" benefit in the "What's Covered" section when furnished by an In-Network Pharmacy.
- Compound ingredients within compound drugs are covered when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Prescription Drugs used to treat infertility.

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

Benefits include Covered Prescription Drugs that are given to you while you participate in an approved clinical trial. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated. The Experimental / Investigational Drug itself is not covered. For more information, please see the "Clinical Trials" benefit in the "What's Covered" section.

Where You Can Get Prescription Drugs

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

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

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

In-Network Pharmacy

Benefits are available for covered Prescriptions when purchased at an In-Network Retail Pharmacy, the PBM's Home Delivery (Mail Order) Pharmacy or the PBM's Specialty Pharmacy. In-Network Pharmacies accept Anthem's allowable benefit as payment in full for Covered Services. For a list of Pharmacies in the network, please visit Anthem's website www.anthem.com.

Give the In-Network Pharmacy the prescription from your Doctor and your ID 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 ID 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 Anthem with a written request for payment.

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

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

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as

heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at 1-855-748-1805 or check our website at www.anthem.com for more details.

Specialty Pharmacy

We have a list of certain Specialty Drugs that we may require you or your doctor to order from the PBM's Specialty Pharmacy. This list may change from time to time. Specialty Drugs that you must receive from the Specialty Pharmacy are limited distribution drugs as well as those Drugs that require special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. If you or your provider believes that your retail pharmacy can provide the special handling, provider coordination, and / or patient education, you may contact us at the Member Services number on the back of your ID Card 1-855-748-1805 to request an exception to receive the Specialty Drug at the retail pharmacy.

When you use the PBM's Specialty Pharmacy, its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at 1-855-748-1805 or check our website at www.anthem.com.

Home Delivery Pharmacy

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

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 if the Prescription Drug you are taking is a Maintenance Medication, please call Member Services at 1-855-748-1805 or check our website at www.anthem.com for more details.

Out-of-Network Pharmacy

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

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

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

What You Pay for Prescription Drugs

Tiers

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

You pay the Deductible and Coinsurance as shown on your Schedule of Benefits.

As required by law, "Preventive Care" pharmacy services are covered in full when furnished by an In-Network Pharmacy with a Prescription from your Doctor. Please see "Preventive Care" in the "What's Covered" section for more information.

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

Anthem assigns Drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. Anthem decides coverage for doses and administration methods (i.e., oral, injection, topical, or inhaled) according to the definition of Medical Necessity stated in the "Definitions" section of this Booklet. Anthem may cover one form of administration instead of another, or put other forms of administration in a different tier.

Orally Administered Anti-Cancer Medications Cost Sharing Limitation. As required by law, the following cost sharing limitations apply to orally administered anti-cancer medications furnished by a pharmacy, provided that an intravenously administered or injected anti-cancer medication is not medically appropriate.

- Your Deductible applies.
- If your plan includes a Coinsurance amount after the Deductible is met, your share of the cost will not exceed your Deductible plus $200 per 30-day supply, per prescription.
- If your plan does not include a Coinsurance amount after the Deductible is met, your share of the cost is limited to the Deductible.

The cost sharing limitations for orally administered anti-cancer medications apply to prescriptions furnished by an In-Network Retail Pharmacy, the Home Delivery (Mail Order) Pharmacy or by the Network Specialty Pharmacy.

Prescription Drug List

We also have an Anthem 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 Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also

based on the availability of over-the-counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

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

If you are affected by a deletion to the Prescription Drug List, Anthem will notify you in writing at least 45 days before the change is made.

You may request a copy of the covered Prescription Drug List by calling Member Services at 1-855-748-1805 or visit our website at www.anthem.com. The covered Prescription Drug List is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug List is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List

If you or your Doctor believe that you need a Prescription Drug that is not on the Prescription Drug List, please contact us directly or have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List, or if a non-formulary Prescription Drug that was available during the previous 12 months is removed. The exception process begins when either you, your Doctor or your pharmacist submit an exception request. We will make a coverage decision within 48 hours of receiving your request. A prescription that requires an exception for coverage will be considered approved if the exception process exceeds 48 hours. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 48 hours of receiving your request. 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.

PreventiveRx Benefit

Note: The PreventiveRx benefit covers Prescription Drugs in addition to those required by federal law under the "Preventive Care" benefit.

Your Plan includes the PreventiveRx benefit, which waives the Deductible for Prescription Drugs listed in the PreventiveRx Plus List when you use an In-Network Provider. Please see the "Schedule of Benefits" for details. These drugs have been found useful in preventing disease or illness. You can get a copy of this list at www.anthem.com. This list will be reviewed and updated from time to time.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription fills and refills. You may obtain up to a 90-day supply of Maintenance Medications from a Retail Maintenance Pharmacy.

You may also obtain up to a 90-day supply of Maintenance Medications from other Retail Pharmacies, provided that the Prescription is for a Covered Service, the quantity is ordered by your Physician, does not require Prior Authorization from Anthem and you can demonstrate that you have taken the Drug for a continuous period of one year. Otherwise, Retail Pharmacy and Specialty Pharmacy purchases may be limited to up to a 30-day supply per fill or refill.

You may obtain up to a 90-day supply of Maintenance Medications from the Home Delivery (Mail Order) Pharmacy.

Law regulates supplies of controlled substances. To be eligible for benefits, they must be purchased at a Retail Pharmacy. They cannot be purchased from a Home Delivery Pharmacy.

By law, network retail pharmacies dispensing a 90-day supply of covered prescription drugs must comply with any specified terms, conditions, and reimbursement rates that apply to Anthem's network Home Delivery (Mail Order) Pharmacy which dispenses 90-day prescriptions.

In most cases, you must use a certain amount of your Prescription before it can be refilled. In some cases Anthem may let you get an early refill. For example, Anthem may let you refill your Prescription early if it is decided that you need a larger dose, or if you require an early refill for your eye drops. Anthem will work with the Pharmacy to decide when this should happen. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call Anthem's PBM at 1-866-876-0333 and ask for an override for one early refill. If you need more than one early refill, please call Member Services at 1-855-748-1805.

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 Member Services at the phone number on the back of your ID Card 1-855-748-1805.

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 Member Services at 1-855-748-1805 or log on to the website at www.anthem.com.

Drug Cost Share Assistance Programs

If you qualify for and participate in 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 an In-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. However, please note that Anthem 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. 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, because certain Specialty Drugs are not classified as "essential health benefits" under the Plan in accordance with the Affordable Care Act, any Member cost-share payments for these Specialty

Drugs will not count towards the Plan's Deductible or Out-of-Pocket Limit and will not be paid at 100% of the Maximum Allowed Amount after the Out-of-Pocket Limit is reached. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

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 Benefits.

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time Anthem 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.

Rebate Impact on Prescriptions 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 will 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 of 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.

What's Not Covered

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

Anthem determines whether services or supplies are Medically Necessary based on the definition of Medical Necessity found in the "Definitions" section.

1) **Administrative Charges**
   - Charges to complete claim forms,
   - Charges to get medical records or reports,
   - Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
2) **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.
3) **Alternative / Complementary Medicine -** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   b. Holistic medicine,
   c. Homeopathic medicine,
   d. Hypnosis,
   e. Aroma therapy,
   f. Massage and massage therapy,
   g. Reiki therapy,
   h. Herbal, vitamin or dietary products or therapies,
   i. Naturopathy,
   j. Thermography,
   k. Orthomolecular therapy,
   l. Contact reflex analysis,
   m. Bioenergetic synchronization technique (BEST),
   n. Iridology-study of the iris,
   o. Auditory integration therapy (AIT),
   p. Colonic irrigation,
   q. Magnetic innervation therapy,
   r. Electromagnetic therapy,
   s. Neurofeedback / Biofeedback.
4) **Autopsies -** Autopsies and post-mortem testing when requested by an entity other than Anthem.
5) **Before Effective Date or after Termination Date -** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
6) **Certain Providers -** Services you get from Providers that are not licensed or otherwise permitted by law and was determined by Anthem to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

7) **Charges Not Supported by Medical Records -** Charges for services not described in your medical records.

8) **Charges over the Maximum Allowed Amount -** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.

9) **Clinical Trial Non-Covered Services -** 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.

10) **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 Member Services at 1-855-748-1805 or visit our website at www.anthem.com.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

11) **Complications of / or Services Related to Non-Covered Services -** Services, supplies, or treatment related to, or for problems directly resulting from, 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.

12) **Compound Ingredients -** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and / or pharmaceutical adjuvants.

13) **Cosmetic Services -** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to "Reconstructive Surgery" as stated under "Surgery" in the "What's Covered" section.

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

15) **Delivery Charges -** Charges for delivery of Prescription Drugs.

16) **Dental Devices for Snoring -** Oral appliances for snoring.

17) **Dental Services -** Coverage is not provided for the following Dental-related services:

- Dental services or health care services not specifically covered under the plan (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
- Services of 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.
- Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- 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 of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.
- Interim or temporary services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the plan.
- Bacteriologic tests, unless covered by the medical benefits of this plan.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this plan.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless 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.
- Secondary diagnostic tests in addition to the primary therapy.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions include instructions or guidance on tooth brushing technique, flossing and / or use of special oral hygiene aids.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the effective date of this plan or received after the coverage under this plan has ended.
- Dental services given by someone other than a licensed provider (dentist or Physician) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this plan.
- 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.

18) **Disease or Injury Sustained as a Result of War or Participation in Riot or Insurrection -** No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war or participation in a riot or an insurrection.

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

20) **Drugs over Quantity or Age Limits -** Drugs which are over any quantity or age limits based upon FDA labeling.

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

22) **Drugs 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 or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

23) **Drugs Prescribed by Providers Lacking Qualifications / Certifications -** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications including certifications, as determined by Anthem.

24) **Durable Medical Equipment (DME), Medical Devices and Supplies**

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss / theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Non-Medically Necessary enhancements to standard equipment and devices.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum 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.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

25) **Educational Services –** 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.

26) **Emergency Room Services for non-Emergency Care -** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes services such as suture removal in an emergency room. For non-Emergency Care please use the closest In-Network Urgent Center or your Primary Care Physician.

27) **Experimental or Investigational Services -** Services or supplies that are Experimental / Investigational as defined in the "Definitions" section of this Booklet. Except as stated under "Clinical Trials" in the "What's Covered" section, this exclusion also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if it is Experimental / Investigational.

28) **Eyeglasses and Contact Lenses -** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

29) **Eye Exercises -** Orthoptics and vision therapy.

30) **Eye Surgery -** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

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

32) **Foot Care -** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    - Cleaning and soaking the feet.
    - Applying skin creams to care for skin tone.
    - Other services that are given when there is not an illness, injury or symptom involving the foot.

33) **Foot Orthotics -** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

34) **Foot Surgery -** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

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

36) **Free Care -** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

37) **Growth Hormone Treatment -** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

38) **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.

39) **Home Health Care**

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.
- Food, housing, and home delivered meals.
- Homemaker services, except for the homemaker visits described in the “What’s Covered” section under “Home Health Care” (prenatal and postpartum visits) and under “Hospice.”

40) **Hospital Services Billed Separately -** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

41) **Hyperhidrosis Treatment -** Medical and surgical treatment of excessive sweating (hyperhidrosis).

42) **Infertility Treatment** which is considered Experimental / Investigational, non-medical costs related to third-party reproduction. For surrogates or gestational carriers there is no coverage for the preparation or introduction of embryos, oocytes, or donor sperm. Services related to sterilization or reversal of sterilization are not covered.

43) **Lost or Stolen Drugs -** Refills of lost or stolen Drugs.

44) **Maintenance Therapy -** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services” as described in the “What’s Covered” section.

45) **Medical Chats Not Provided through Our Mobile App -** Texting or chat services provided through a service other than our mobile app.

46) **Medicare** for which benefits are payable under Medicare Parts A and / or B, except as required by law, as described in the section titled "Medicare" in “General Provisions.”

47) **Missed or Cancelled Appointments -** Charges for missed or cancelled appointments.

48) **Naturopathic Medicine Services -** Alternative / Complimentary medicine naturopathy services you get from a Doctor of Naturopathic Medicine.

49) **Non-approved Drugs** - Drugs not approved by the FDA.

50) **Non-Approved Facility** - Services from a Provider that does not meet the definition of Facility.

51) **Non-Medically Necessary Services -** Services that are not Medically Necessary as defined in the “Definitions” section of this Booklet.

52) **Nutritional or Dietary Supplements -** Nutritional and / or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

53) **Oral Surgery -** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

54) **Personal Care, Convenience and Mobile / Wearable Devices**

- Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).
- Home workout or therapy equipment, including treadmills and home gyms.
- Pools, whirlpools, spas, or hydrotherapy equipment.
- Hypo-allergenic pillows, mattresses, or waterbeds.
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

- Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

55) **Private Duty Nursing -** Private Duty Nursing Services.

56) **Prosthetics -** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics except as required by law.

57) **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.

58) **Routine Physicals -** Physical exams required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

59) **Sanctioned or Excluded Providers -** Any service, Drug, Drug regimen, treatment or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S, Department of Health and Human Services Office of Inspector General List of Excluded Individuals / Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion lists or other exclusion / sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

60) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits -** Services that Anthem determines require in-person contact and / or equipment that cannot be provided remotely.

61) **Services Received Outside of the United States -** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care, Emergency Ambulance or Covered Services approved in advance by Anthem.

62) **Sexual Dysfunction -** Services or supplies for male or female sexual problems.

63) **Smoking Cessation Programs -** Programs to help you stop smoking. Please note: Preventive screenings, counseling and other Preventive Care services for tobacco use and tobacco cessation are covered as required by law under the "Preventive Care" benefit in the "What's Covered" section and in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

64) **Stand-By Charges -** Stand-by charges of a Doctor or other Provider.

65) **Reversal of Elective Sterilization**

66) **Surrogate Mother Services -** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

67) **Temporomandibular Joint Treatment -** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

68) **Travel Costs -** Mileage, lodging, meals, and other Member-related travel costs except as described under "Ambulance Services" in the "What's Covered" section of this Booklet.

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

70) **Vision Services -** We will not pay for services incurred for, or in connection with, any of the items below:

- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For Plano lenses (lenses that have no refractive power).
- Blended lenses.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- Vision services not listed as covered in this Booklet.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
- 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.
- For Members through age 18, no benefit is available for frames or contact lenses purchased outside of Anthem's formulary.
- 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.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing, unless covered by the medical benefits of this Booklet.
- For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as covered under the medical benefits of this plan.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

71) **Weight Loss Programs -** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This Exclusion does not apply to the "Diabetes Management" or "Preventive Care" benefits or to "Surgery for conditions caused by obesity" under "Surgery" in the "What's Covered" section.

72) **Wilderness or other outdoor camps and / or programs.**

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

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

1. **Administration Charges -** Charges for the administration of any Drug except for covered immunizations as approved by Anthem or the PBM.
2. **Charges not Supported by Medical Records -** Charges for pharmacy services not related to conditions, diagnoses and / or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services -** 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.
4. **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 Member Services at 1-855-748-1805 or visit our website at www.anthem.com.

   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
5. **Compound Ingredients -** Compound ingredients that are not FDA approved or do not require a Prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **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.
7. **Cosmetic Drugs Agents or medications used for cosmetic purposes.**
8. **Delivery Charges -** Charges for delivery of Prescription Drugs.
9. **Drugs Given at the Provider's Office / Facility -** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit in the "What's Covered" section - they are Covered Services.
10. **Drugs Not on the Anthem Prescription Drug List (a formulary) -** You can get a copy of the list by calling us at 1-855-748-1805 or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prior Authorization" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
11. **Drugs over Quantity or Age Limits -** Drugs which are over any limits quantity or age limits based upon FDA labeling.
12. **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.
13. **Drugs Prescribed by Providers Lacking Qualifications / Certifications -** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.
14. **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 or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

Please see “Over-the-Counter Items” below for information about coverage required by law for over-the-counter items purchased at an In-Network Pharmacy with a Prescription from your Doctor.

15. **Family Members Services -** prescribed, ordered referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
16. **Fraud, Waste, Abuse, and Other Inappropriate Billing -** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
17. **Gene Therapy -** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the “Cellular and Gene Therapy Services” benefit. Please see that section for details.
18. **Growth Hormone Treatment** - Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
19. **Hyperhidrosis Treatment -** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
20. **Items Covered as Durable Medical Equipment (DME) -** Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors and contraceptive devices. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” may be covered under the “Durable Medical Equipment (DME), Medical Devices, and Supplies” benefit in the “What’s Covered” section. Please see that section for details.
21. **Items Covered Under the “Allergy Services” Benefit -** Allergy desensitization products or allergy serum. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, these items may be covered under the “Allergy Services” benefit in the “What’s Covered” section. Please see that section for details.
22. **Lost or Stolen Drugs -** Refills of lost or stolen Drugs.
23. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider -** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
24. **Non-approved Drugs -** Drugs not approved by the FDA.
25. **Non-Medically Necessary Services -** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
26. **Nutritional or Dietary Supplements -** Nutritional and / or dietary supplements, except as described in this Booklet or that we must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
27. **Onychomycosis Drugs -** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
28. **Over-the-Counter Items -** 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 may not be covered, even if written as a Prescription Order. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover by law under “Preventive Care” in the “What’s Covered” section when you purchase them from an In-Network Pharmacy with a Prescription from your Doctor. These include over-the-counter contraceptive products for women and over-the-counter smoking cessation / nicotine replacement products (limited to nicotine patches and gum), low-dose aspirin and colonoscopy prep medications, or to FDA-approved over-the-counter hearing aids when Members have been certified as deaf or hearing impaired by a Physician or licensed audiologist.

29. **Sanctioned or Excluded Providers -** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of the Inspector General List of Excluded Individuals / Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion / sanctioned lists as published by Federal or State regulatory agencies.
30. **Sexual Dysfunction Drugs -** Drugs to treat sexual or erectile problems.
31. **Syringes -** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
32. **Weight Loss Drugs -** Any Drug mainly used for weight loss.

Claims Payment

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

Maximum Allowed Amount

General

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

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

- That meet Anthem's definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in this Booklet.

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

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.

When you receive Covered Services from a Provider, Anthem 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 Anthem's determination of the Maximum Allowed Amount. Anthem's application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means Anthem has 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, Anthem may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific health care plan or in a special Center of Medical Excellence / or other closely managed specialty network, or who has a participation contract with Anthem. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services at 1-855-748-1805 for help in finding an In-Network Provider or visit Anthem's website at www.anthem.com.

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

For Covered Services you receive from an Out-of-Network Provider, for Emergency Care or for services approved as a Referral, the Maximum Allowed Amount for this Plan will be one of the following as determined by us:

1. An amount based on Anthem's Out-of-Network Provider fee schedule / rate, which has been established at Anthem's discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like / similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, and other industry cost, reimbursement and utilization data, or

2. An amount based on the level and / or method of reimbursement used by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies, 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 Anthem 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 equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount 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. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the

Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

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

Member Cost Share

For certain Covered Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and / or Coinsurance).

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, Anthem may authorize the In-Network cost share amounts (Deductible, Copayment or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim involves a Surprise Billing Claim. Please contact Member Services for additional information or to request authorization. The telephone number is 1-855-748-1805.

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.

Claims Review

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

Notice of Claim & Proof of Loss – Post-Service Claims

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-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.

- Out-of-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 within 15 days of your request to file proof of loss on a claim form, the time for submission will be met if you submit a written claim for benefits within the time limit stated in this section. Your written claim for benefits must include the same information that would be given on Anthem's prescribed claim form. This includes:

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

  Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. 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.

Legal Action

No action may be brought to recover benefits for any service covered under this Booklet unless the required notice or proof of claim has been given to Anthem within the time frame required under this Booklet and such action is commenced prior to the expiration of 60 days after proof of claim has been filed and no later than 3 years following the date that the notice or proof of claim has or should have been provided to Anthem.

Post-Service Claim Determinations

Timeframe for Post-Service Claim Determinations - Anthem will make a Post-Service Claim determination within 30 days after receipt of the claim unless you or your authorized representative fail to provide the information needed to make a determination. In the case of such failure, Anthem will notify you within 15 days after receipt of the claim. Anthem's notice will state the specific information needed to make a determination. You will be provided at least 45 days to respond to Anthem's notice. The period of time between the date of the request for information and the date of Anthem's receipt of the information is "carved out" of (does not count against) the 30-day time frame stated in this paragraph.

Prompt Payment of New Hampshire Provider Post-Service Claims - In addition to the Post-Service Claim determination rules stated in "Timeframe for Post-Service Claim Determinations" (above), the

following applies to claims for Covered Services furnished by a New Hampshire Provider: Claims will be paid according to the terms of New Hampshire law. Clean written claims will be paid within 30 calendar days of receipt. Clean electronic claims will be paid within 15 calendar days of receipt. If Anthem fails to pay an initial claim within the timeframes, Anthem will pay the Provider or Member the eligible benefit for the claim plus an interest payment of 1.5% per month beginning from the date payment was due.

Payment of a claim is considered made on the date the check is issued or electronically transferred. Anthem will mail checks no later than 5 business days after the date of issue.

A "clean claim" is a claim for payment of Covered Services rendered by a New Hampshire Provider and meeting the following requirements: The claim is submitted on Anthem's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with Anthem's published filing requirements.

"Electronic claims" means the transmission of data for the purpose of payment of claims for Covered Services furnished by a New Hampshire Provider, the claim being submitted in an electronic data format specified by Anthem.

If payment is denied or delayed, Anthem will notify the Provider or Subscriber within 15 calendar days of receipt. The notice will include the reason for denial or delay and an explanation of any additional information needed to complete processing. Anthem will adjudicate the claim within 45 calendar days of receipt of the additional information. If the notice of denial or delay is not made as required, the claim will be subject to the timeframes for clean claims stated above in this subsection.

Pre-Service Claims

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

Pre-Service Claims may be non-urgent or urgent

An example of a non-urgent Pre-Service Claim is a request for Precertification of a scheduled Inpatient admission for elective surgery.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

Timeframes for Making Pre-Service Claim Determinations - Anthem will make a determination about your Pre-Service Claim within the following time frames. Time frames begin when your claim is received and end when a determination is made.

- **For non-Urgent Claims** a determination will be made within a reasonable time period, but in no more than 15 days after receipt of the claim.

  Exception: the initial 15-day period may be extended one time for up to 15 additional days, provided that Anthem finds that an extension is necessary due to matters beyond the control of Anthem. Before the end of the initial 15-day period, you will be notified of the circumstances requiring an extension. The notice will also inform you of the date by which a decision will be made. If the extension is necessary because you or your authorized representative failed to provide the information needed to make a determination, the notice of extension will specify the additional information needed. You will be given at least 45 days from receipt of the notice to

provide the specified information. The determination will be made as soon as possible, but in no case later than 15 days after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

- **For Urgent Care Claims** a determination will be made as soon as possible, taking into account the urgencies of your medical condition, but no later than 72 hours after receipt of the claim.

- **Exception:** If you or your authorized representative fail to provide the information needed to make a determination, Anthem will notify you within 24 hours after receipt of the claim. The notice will include the specific information necessary to make a determination. You will be given no less than 48 hours to provide the information. The determination will be made as soon as possible, but in no case later than 48 hours after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

- **For Urgent Care Claims Relating to *both* the Extension of an Ongoing Course of Treatment *and* a Question of Medical Necessity,** a determination will be made within 24 hours of receipt of the claim, provided that you make the claim at least 24 hours *before* the approved period of time or course of treatment expires.

No fees for submitting a Pre-Service Claim will be assessed against you or your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or benefit determination by submitting your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact Member Services. The toll-free telephone number is 1-855-748-1805.

Exception: For Urgent Care Claims, Anthem will consider a health care professional with knowledge of your condition (such as your treating Physician) to be your authorized representative without requiring your written acknowledgment of the representation.

Notice of a Claim Denial

Claim Denial means any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Member's eligibility for coverage under this Booklet. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of utilization review procedures, as well as failure to cover a service for which benefits are otherwise provided based on a determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

Anthem's notice of a Post-Service or a Pre-Service Claim Denial will be in writing or by electronic means and will include the following:

- The specific reason(s) for the determination, including the specific provision of your plan on which the determination is based.

- A statement of your right to access the internal appeal process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, Anthem will include a description of the expedited review process.

- If the Claim Denial is based upon a determination that the claim is Experimental / Investigational or not Medically Necessary or appropriate, the notice will include:

    1. The name and credentials of Anthem's Medical Director, including board status and the state(s) where the Medical Director is currently licensed. If a person or other licensed entity making the Claim Denial is not the Medical Director but a designee, the designee's credentials, board status,

and state(s) of current license will be included, and

2. An explanation of the clinical rationale or the scientific judgment for the determination. The explanation will recite the terms of your plan or of any clinical review criteria or internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstances.

- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Claim Denial, a statement that such guideline was relied upon. A copy of the guideline will be included with the notice, or you will be informed that a copy is available free of charge upon request.

- If clinical review criteria were relied upon in making any Claim Denial, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale provided will be accompanied by the following notice: "The clinical review criteria provided to you are used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your Booklet."

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

Member's Cooperation

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

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and / or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), 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. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

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

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and / or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

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.

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 or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by 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. Remember to take an up-to-date health ID Card with you.

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

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.

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

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

Applicability

Please note: You may not hold, or obtain benefits under both this plan and a non-group (individual) health insurance policy issued by Anthem or any other insurer.

The Coordination of Benefits (COB) provisions in this section set the payment responsibilities when you are covered by more than one health or dental care plan or policy. COB is intended to prevent duplication of payment and overpayments for Covered Services furnished to Members. If any Member is covered under another health care plan or policy, benefits for Covered Services will be coordinated as stated in this section.

For purposes of this section only, “health care plan” or “policy” means any of the following, which provide benefits or services for, or by reason of, medical or dental care or treatment:

- Group or individual hospital, surgical, dental, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as “socialized medicine” plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits.

- Except as stated in this section, any insurance policy, contract or other arrangement or insurance coverage, where a health or dental benefit is provided, arranged or paid, on an insured or uninsured basis.

- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

- The medical benefits coverage in automobile “no fault” or “personal injury protection” (PIP) type contracts, not including medical payments coverage, also known as Part B in the personal automobile policy or med pay.

For the purposes of this section, the terms “health care plan” or “policy” do not refer to:

- Hospital indemnity coverage or benefits or other fixed indemnity coverage,

- Accident only coverage,

- Specified disease or specified accident coverage,

- Limited benefits health coverage, as defined in New Hampshire regulations,

- School accident-type coverages that cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis,

- Medical payments coverage in a personal automobile policy, also known as Part B or med pay,

- Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services,

- Medicare supplement policies,

- A state plan under Medicaid, or

- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

The term "health care plan or policy" will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or

- That portion of any such policy, contract or other arrangement for benefits or services which reserves the right to take the benefits of the other health care plan or policy into consideration in determining its benefits and that portion which does not take such benefits into consideration.

COB also applies when you are covered by more than two policies.

Please remember that your cost sharing amounts (such as Copayments, Deductible and Coinsurance) or annual and lifetime maximums are your responsibility whether Anthem is the Primary or the Secondary plan. Also, plan rules apply as stated in this section whether Anthem is the Primary or the Secondary plan. For example, any applicable provider network or participation rules apply.

Definitions

The following definitions apply to the terms of this section:

Primary means the health or dental care plan or policy that is responsible for processing your claims for eligible benefits first. When this health care plan is the Primary plan, Anthem will provide the full extent of benefits for services covered under this Booklet, up to Anthem's Maximum Allowed Amount without regard to the possibility that another health care plan or policy may cover some expenses.

Secondary means the plan responsible for processing claims for Allowable Expenses after the Primary plan has issued a benefit determination. When this health care plan is Secondary, benefits under this plan may be reduced so that payments from all health care plans or policies combined do not exceed 100% of the total Allowable Expense.

Allowable Expense means a health or dental care service expense that is eligible for Secondary benefits under this health care plan. Allowable Expenses include any Deductible, Coinsurance and Copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

- An expense must be for a Medically Necessary Covered Service, as defined in this Booklet. Otherwise, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.

- When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this plan:

    a. If all plans covering the claim compute benefits or services based on a usual and

customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.

b. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

c. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology and another computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans.

Exception: If an In-Network Provider contracts with Anthem to accept a negotiated amount as payment in full when Anthem is the Secondary payer and such negotiated amount differs from the Primary payer's arrangement, Anthem's negotiated amount will be the Allowable Expense used to determine Secondary benefits. The total amount in payments and / or services provided by all payers combined will not exceed Anthem's Maximum Allowed Amount.

- If the Primary plan bases payment for a claim on the Provider's full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies, other similar reimbursement methodologies and does not negotiate fees with Providers, the combination of benefits paid by the Primary plan and this plan will not exceed Anthem's Maximum Allowed Amount. The difference between Anthem's Maximum Allowed Amount and the Provider's charge is not an Allowable Expense.

- When benefits are reduced under a Primary plan due to an individual's failure to comply with the Primary plan's provisions, the amount of the reduction is not an Allowable Expense. Examples of these types of plan provisions include managed care requirements for second surgical opinions, Inpatient and Outpatient Precertification requirements and rules about access to care (such as network restrictions and Referral rules).

- Any expense that a health care Provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

- The amount that is subject to the Primary high-deductible health plan's Deductible is not an Allowable Expense if Anthem has 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.

Order of Benefit Determination Rules

COB uses the following rules to determine the Primary and Secondary payers when you are covered by more than one health care plan or policy.

General Rules

- Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the benefits available under this Booklet or any rider, endorsement or other amendment to this Booklet. Factors that determine which plan is Primary include the number of individuals employed by your Group, your status as an active employee, your age and the reason that you are eligible for Medicare. If Medicare is the Secondary plan according to MSP laws, coverage under this Booklet is Primary. If Medicare is the Primary plan according to MSP laws, coverage under this Booklet is Secondary.

  If you are entitled to Medicare benefits when you enroll in this Plan, you must inform your Group

Benefits Administrator and state this information on your enrollment form. If you become entitled to Medicare benefits after you enroll in this Plan, you must inform your Group Benefits Administrator and Anthem immediately. You should also contact your local Social Security Office right away to discuss Medicare rules regarding enrollment in Parts A, B and D of Medicare.

The following applies when this Plan is Secondary to Medicare: If you are eligible for Medicare but not enrolled in Medicare or you are entitled to Medicare Part A and not enrolled in Medicare Part B, you are encouraged to contact your local Social Security Office to discuss Medicare rules regarding enrollment.

- To the extent permitted by applicable law, when any benefits are available as Primary benefits to a Member under Medicare or any Workers' Compensation Laws, Occupational Disease Laws and other employer liability laws, those benefits will be Primary.

- If you have coverage under this plan and any plan outside the U.S.A. (including plans administered by a government, such as "socialized medicine" plans), the out-of-country plan is Primary when you receive care outside the U.S.A. This plan is Primary when you receive services in the U.S.A. This rule applies before any of the following rules (including the rules for children of separated or divorced parents).

- Except for group coverage that supplements a basic part of a benefit package and provides supplementary coverage, any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this section is always Primary.

Coordination of Benefits (COB) Rules

If you are covered by more than one health or dental care plan or policy and none of the rules listed in "General Rules" (above) apply, the order of benefits will be determined by using the first of the following rules that apply:

- **Dental Coordination of Benefits (COB)** - These Dental COB provisions are applicable only when dental services are covered under the "Dental Services" part in the "What's Covered" section of this Booklet.

  a. If dental Essential Health Benefits are included as part of the medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary.

  b. If the member has two medical plans, each offering dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determination rules below apply.

- **Non-Dependent / Dependent** - If you are the employee or Subscriber under one policy and you are a dependent under the other, the policy under which you are an employee or Subscriber is Primary.

  Exception: If you are a Medicare beneficiary and, as a result of federal law, Medicare is Secondary under the plan covering you as a dependent and Primary to the Plan covering you as an employee or Subscriber, then the order of benefits is reversed so that the plan covering you as an employee or Subscriber is the Secondary plan and the other plan is Primary.

- **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:

  1. For a dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:

     a. The plan of the parent whose birthday falls earlier in the Calendar Year is Primary, or

b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care 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, or

b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the "birthday rule" in 1 above shall determine the order of benefits.

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the "birthday rule" in 1 above shall determine the order of benefits.

d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(1) The plan covering the Custodial parent;

(2) The plan covering the spouse of the Custodial parent;

(3) The plan covering the non-Custodial parent; and then

(4) The plan covering the spouse of the non-Custodial parent.

A 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.

e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of 1 or 2 above shall determine the order of benefits as if those individuals were the parents of the child.

- **Active Employee or Retired or Laid-off Employee** - The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is 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 the "Non-Dependent / Dependent" rule (above) can determine the order of benefits.

- **COBRA or State Continuation Coverage -** If a Member is covered under COBRA or a similar "right of continuation" law under either federal or a state law, and the Member is also covered under another policy that is not a continuation policy, the continuation coverage is Secondary and the other plan is Primary. 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 the "Non-Dependent/Dependent" rule (above) can determine the order of benefits.

- **Longer / Shorter Length of Coverage** - The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is Primary and the plan that covered the Member the short period of time is Secondary.

- **If the preceding rules do not determine the order of benefits**, Allowable Expenses shall be shared equally between the health care plans or policies. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

Anthem's Rights Under This Section

To carry out the terms of this section, Anthem reserves the right to:

- Take any action needed to carry out the terms of this section, and
- Exchange information with your other insurance company or other party, and
- Recover Anthem's excess payment from another party or reimburse another party for its excess payment, and
- Take these actions when Anthem decides they are necessary without notifying the Member.

This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information. Neither does this provision permit (in any manner) the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been made by Anthem in accordance with this section, Anthem has the right, at its sole discretion, to pay the other plan or entity any amount that Anthem determines to be warranted to satisfy the intent of this section. Amounts so paid are benefits under this Booklet and, to the extent of such payments, Anthem is fully discharged from liability under this Booklet.

Your Agreement and Responsibility

You have the responsibility to provide prompt, accurate and complete information to Anthem about other health coverages and / or insurance policies or benefits you may have in addition to Anthem coverage. Other health coverages, insurance policies or benefits include benefits from other health coverage, Worker's Compensation, and / or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition you receive. By accepting this Booklet, you agree to cooperate with Anthem, and you agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Booklet.

By accepting this Booklet, you must:

- Promptly notify Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to you occurred and all information regarding the parties involved and any other information requested by Anthem,
- Cooperate with Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice Anthem's rights,
- Send to Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to you, and / or
    - Promptly notify Anthem if you retain an attorney or if a lawsuit is filed on your behalf. Any action which interferes with Anthem's rights under this Booklet may result in the termination of coverage for the Subscriber and covered Dependents, and
    - Immediately notify Anthem if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

Subrogation and Reimbursement

These provisions apply when Anthem pays benefits as a result of injuries, illness, impairment or medical condition you sustain and you have a right to a recovery or have received a recovery. For the purposes of this Section, "recovery" shall mean money you receive from another, the other's insurer or from any "Home Owner's," "Uninsured Motorist," "Underinsured Motorist," "No-Fault," "Personal Injury Protection" or other insurance coverage provision as a result of injury, illness, impairment or medical condition caused by another party. These provisions do not apply to medical payments coverage, also known as Part B in a personal automobile policy or med pay. Regardless of how you or your representative or any agreements characterize the recovery you receive, it shall be subject to the Subrogation and Reimbursement provisions of this section.

Benefits will be provided for medical care paid, payable or required to be provided under this Booklet, and the benefits paid, payable or required to be provided. Anthem must be reimbursed by the Member for such payments as permitted under applicable law from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

Anthem may reduce any benefit paid, payable or required to be paid under this Booklet by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

If benefits are exhausted under a medical payments coverage or other similar property and casualty insurance, benefits are available under this plan, subject to all of the terms and conditions of this Booklet.

Subrogation - If you suffer an injury, illness, impairment or medical condition that is the result of another party's actions, and Anthem pays benefits to treat such injury, illness, impairment or medical condition, Anthem will be subrogated to your recovery rights. Anthem may proceed in your name against the responsible party. Additionally, Anthem shall have the right to recover payments made on your behalf from any party responsible for compensating you for your injury, illness, impairment or medical condition. All of the following shall apply, except to the extent limited by applicable law:

- Anthem may pursue its subrogation rights for the full amount of benefits Anthem has paid from any recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable Anthem to exercise the rights set forth in this Section and do nothing to prejudice such rights.

- Anthem has the right to take whatever legal action is seen fit against any party or entity to recover benefits paid under this Plan.

- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full Anthem's subrogation claim and any claim still held by you, Anthem's subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.

- Anthem is not responsible for any attorney fees, other expenses or costs you incur without the prior written consent of Anthem.

Nothing in this section shall be construed to limit Anthem's right to utilize any remedy provided by law to enforce its rights to subrogation under this section. If you are injured or suffer an impairment or medical condition that is the result of another party's actions, and Anthem pays benefits to treat such injury or condition, Anthem will be subrogated to your recovery rights. Anthem is entitled to reimbursement from the responsible party or any other party you receive payment from to the extent of benefits provided. Anthem's subrogation right includes, but is not limited to, underinsured or uninsured motorists' coverage.

By accepting this Booklet, you agree to cooperate with Anthem and do whatever is necessary to secure Anthem's right and do nothing to prejudice these rights. Anthem reserves the right to compromise on the amount of the claim if Anthem determines that it is appropriate to do so. Any action that interferes with Anthem's subrogation rights may result in the termination of coverage for the Subscriber and covered Dependents. Any recovery you obtain must not be dissipated or disbursed until such time as Anthem has been repaid in accordance with these provisions.

Reimbursement - If you obtain a recovery, Anthem has a right to be repaid promptly from the recovery up to the amount of the benefits paid by Anthem on your behalf.

Member Satisfaction Services, Appeals and External Review Procedures

Member Satisfaction Services

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

- Answer questions you have about your membership, your benefits, Covered Services, the network, payment of claims, and about policies and procedures,
- Provide information or health plan materials that you want or need (such as health promotion brochures, the network directory, or replacement of ID Cards),
- Make sure your suggestions are brought to the attention of the appropriate persons, and
- Provide assistance to you (or your authorized representative) when you want to file an internal appeal.

Your identification number helps to locate your important records with the least amount of inconvenience to you. Your identification number is on your ID Card. Please be sure to include your entire identification number (with the three-letter prefix) when you call or write.

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services at 1-855-748-1805. 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 an appeal. Please see "Internal Appeal Procedure," (below) for complete information about the internal appeal procedure. You may have the right to an independent External Review, as summarized under "External Review Through The New Hampshire Insurance Department," (below).

If you have a concern about the quality of care offered to you in the network (such as waiting times, Physician behavior or demeanor, adequacy of facilities or other similar concerns), you are encouraged to discuss the concerns directly with the Provider before you contact a Member Services Representative.

Prescription Drug List Exceptions

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

Please contact **Anthem's Member Services Center** about your membership, benefits, Covered Services, plan materials, the network or network Providers. The toll-free telephone number is 1-855-748-1805	Or, you may write to: Member Services Center Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, CT 06473-0660
You may choose to contact the **State of New Hampshire Insurance Department** for assistance at any time during business hours. Call the Insurance Department at: 1-800-852-3416	Or, you may write to: Life, Accident and Health Consumer Affairs Coordinator New Hampshire Insurance Department 21 South Fruit Street, Suite 14 Concord, NH 03301
For more information about Member services, please visit Anthem's website at www.anthem.com.	

Internal Appeal Procedure

You have the right to receive benefits for Covered Services, as described in this Booklet. You may appeal any Claim Denial made by Anthem. This section explains the internal appeal procedure.

Please see the "Definitions" section in this Booklet for definitions of "Adverse Determination", "Claim Denial," "Urgent Care Claim," "Pre-Service Claim" and "Post-Service Claim."

Who may submit an internal appeal? You or your authorized representative may submit an internal appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact Member Services. The toll-free telephone number is 1-855-748-1805.

  Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of your condition (such as your treating Physician) to be your authorized representative without requiring your written acknowledgment of the representation, or

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

What should be included with an internal appeal? Please include your identification number (including the three-letter prefix) and describe the services that you are submitting for review. If possible, refer to the date you received the service and state the name of the Doctor, Hospital or other Provider that furnished the care. You may also want to include:

- Bills that you have received from the Provider, and

- Any information that you believe is important for review, such as statements from your Physician or letters you received from Anthem.

- You may point out the portion of this Booklet that you believe pertains to your appeal. You should state the outcome you are expecting as a result of your appeal.

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

INTERNAL APPEAL PROCESS:

You may call or write to initiate an internal appeal. Letters should be addressed to:

For medical and Prescription Drug or Pharmacy Issues:

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

For "Dental Services" Issues:

Anthem Blue Cross and Blue Shield
PO Box 1122
Minneapolis, MN 55440-1122

For "Vision Services for Members Through Age 18" and "Vision Services for Members Age 19 and Older" Issues:

Anthem Blue Cross and Blue Shield /
Blue View Vision
PO Box 9304
Minneapolis, MN 55440-9304

Your appeal must be submitted within at least 180 days of Anthem's notification about the issue that caused you to appeal.

By accepting this Booklet, you agree that the internal appeal procedure provides that one mandatory level of internal appeal is available to you. Your obligation to follow the mandatory appeal procedure is fulfilled when:

- The internal appeal is completed, or
- You seek External Review of an Adverse Determination before the internal appeal is complete, in keeping with the terms of "External Review Through the New Hampshire Insurance Department" (below).

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

Expedited Appeals - An expedited appeal procedure is available for Urgent Care Claim Denials, or Claim Denials concerning an admission, availability of care, continued stay or health care service for Members who have received emergency services, but who have not been discharged from a Facility. You may submit information to support your appeal by telephone, facsimile or other expeditious method. Anthem will make a decision and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours. If an initial notice of the determination is not in writing, a written confirmation of the decision will be provided to you within two business days.

If you or your authorized representative fail to provide the information needed to make a determination, Anthem will notify you within 24 hours after receipt of your appeal.

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

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

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

Please note: You may be eligible for an independent External Review overseen by the New Hampshire Insurance Department before completing the internal appeal process. Please see "External Review Through the New Hampshire Insurance Department," (below) for more information.

Content of Notice of an Appeal Determination - You will be notified in writing of the appeal determination. If the denial of benefits is upheld, in whole or in part, the written notice will include the following:

- The specific reason(s) for the determination, including reference to the specific provision of this Booklet or plan on which the determination is based,

- If an internal rule, guideline, protocol or other similar provision was relied upon in making the claim denial, a statement that such a rule, guideline, protocol or other similar provision was relied upon,

- If the determination is based upon a finding that the service under appeal is Experimental, Investigational or not Medically Necessary or appropriate, the notice will include:

    - The name and credentials of the person reviewing the appeal, including board status and the state or states where the person is currently licensed, and

    - An explanation of the clinical rationale for the determination. This explanation will recite the terms of this Booklet or of any clinical review criteria or any internal rule, guideline, protocol, or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstance, and

    - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (such as copies of rules, guidelines, protocols or other similar criterion upon which the Claim Denial is based) relevant to your claim for benefits. The records on file with Anthem may be limited in scope. Please contact your Physician if you have questions or concerns about the content of your medical records, and

    - A statement describing all other dispute resolution options available to you, including, but not limited to your options for internal review, external review or for bringing a legal action.

- If the appeal involves an Adverse Determination, a copy of the Insurance Department's *Managed Care Consumer Guide to External Appeal* will be included with the notice. The guide includes the specific requirements for filing an External Review. Please see "External Review Through the New Hampshire Insurance Department," (below) for more information about External Review.

- Appeal determination notices will remind you that you have the right to contact the Insurance Commissioner's office for assistance. The Insurance Commissioner's address and toll-free telephone number will be included in Anthem's notice.

Full and Fair Review - Anthem conducts and oversees internal appeals. No fees for submitting an appeal will be assessed against you or your authorized representative. Please note that oral statements by agents or representatives of Anthem will not change the benefits described in this Booklet.

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

- The person(s) reviewing your appeal will not be the same person(s) who made the initial Claim Denial or a subordinate or supervisor of the person who made the initial Claim Denial.

- In the appeal of a Claim Denial based in whole or in part on a medical judgment, including determinations with regard to whether a service is Experimental, Investigational or not Medically Necessary or appropriate, the appeal will be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition of health problem in question. A practitioner is considered of a similar specialty if he or

she has experience treating the same problems as those in question, in addition to expertise treating similar complications of those problems.

- Also, in the appeal of a Claim Denial based in whole or in part on a medical judgment, Anthem's decision notice will include the titles and qualifying credentials of the person conducting the review. At your request, the identity and qualifications of any medical or vocational expert whose advice was considered in making the initial Claim Denial (without regard to whether it was relied upon) will be provided.

- You have at least 180 days to file an appeal, following receipt of Anthem's Claim Denial notification.

- You may submit written comments, documents, records, and other information relating to your appeal, without regard to whether those documents or materials were considered in making the initial Claim Denial.

- You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to or considered in making the initial Claim Denial.

- Your issue will be considered anew (de novo), as if the issue had not been reviewed before and as if no decision had been previously rendered. All information, documents, and other material submitted for the internal appeal procedure will be considered without regard to whether the information was considered in making a Claim Denial.

- If Anthem considers, relies on or generates any new or additional evidence in connection with your appeal, Anthem will provide you with that new or additional evidence, free of charge. Anthem will not base its appeal decision on a new or additional rationale without first providing it to you, free of charge, and a reasonable opportunity to respond to any such new or additional rationale.

- If Anthem fails to follow the appeals procedures outlined under this section, the internal appeal procedure may be deemed exhausted and you may seek an External Review Through the New Hampshire Insurance Department.

In addition to the internal appeal procedure described above, you may have the right to an External Review arranged through and overseen by the New Hampshire Insurance Department. Please see "External Review Through the New Hampshire Insurance Department," (below) and the Managed Care Consumer Guide to External Appeal (enclosed with this Booklet).

External Review Through the New Hampshire Insurance Department

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

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

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

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

- The service under appeal is a Covered Service and is not subject to an exclusion or an annual or lifetime maximum, as stated in this Booklet. Or, the service would be covered if certain clinical conditions were met and the decision about coverage is therefore an Adverse Determination.

  For example, Anthem may determine that a service is Experimental, Investigational or cosmetic and you disagree. Another example is: Anthem may deny coverage for care outside the network because Anthem finds that appropriate care can be provided in the network and you disagree, and

- Your review request is not for the purpose of pursuing a claim or allegation of health care Provider malpractice, professional negligence or other professional fault, and

- The time frames stated for completion of the internal appeal procedure are not met, or

- You have completed the internal appeal procedure stated in "Internal Appeal Procedure," (above) and the final decision is adverse.

  Exception: If you are eligible for an expedited external review through the New Hampshire Insurance Department, you may pursue the expedited external review simultaneous with Anthem's internal appeal procedure; or

- You and Anthem agree to submit the appeal for External Review before the internal appeal procedure is completed.

Notice: Anthem will provide complete notice of your rights to an External Review when:

- An internal appeal procedure is completed and the final decision is an Adverse Determination, or

- The time frame for completion of an internal Adverse Determination appeal is not met (Anthem's notification will be issued on the day that the time frame expires), or

- You and Anthem agree to waive the internal appeal procedure in order to seek External Review and the appeal in involves an Adverse Determination.

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

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

You must submit your Request for Independent External Appeal of a Health Care Decision to the New Hampshire Insurance Department no later than 180 days after the date of Anthem's notice.

Please contact the Insurance Department if you need assistance with the request forms. The telephone number and address are shown in "Member Satisfaction Services," above.

The Insurance Department's Guide to External Review Rights - You are encouraged to read the New Hampshire Insurance Department's Managed Care Consumer Guide to External Appeal, which is enclosed with this Booklet. The guide contains important information regarding the External Review process and time frames. It explains your rights and responsibilities and those of the Insurance Department, its certified Independent Review Organizations and Anthem.

When handling a review on an expedited basis, the selected Independent Review Organization will make a decision and notify Anthem and you as expeditiously as your medical condition requires, but in no event more than 72 hours after the expedited external review is requested. If the initial notice was not in writing, written confirmation of the decision will be made to you or your authorized representative and to Anthem within 2 business days of the non-written notice. The written notice will state whether Anthem's determination is upheld or reversed. The written notice will also include a statement of the nature of your appeal, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

If an expedited External Review is conducted during your Hospital stay or while you are continuing a course of treatment, your stay or treatment will continue, as directed by your Physician. You will be held harmless for the cost of the care under review, pending the determination of the Independent Review Organization. This provision does not waive your cost sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in this Booklet. If the External Review results are adverse to you, you may be responsible for paying the cost of non-Covered Services, according to the terms and conditions of this Booklet.

The External Review process may terminate only if your External Review request submitted to the New Hampshire Insurance Department includes new information and:

- Anthem reviews the new information, and
- The Adverse Determination is reversed as a result of the reconsideration process.

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

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

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs
- Health benefit plans that are self-funded by employers

Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Disagreement with Recommended Treatment

Your Physician is responsible for determining the health care services that are appropriate for you. You may disagree with your Physician's decisions and you may decide not to comply with the treatment that is

recommended by your Physician. You may also request services that your Physician feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, you have the right to refuse the recommendations of your Physician. In all cases, Anthem has the right to deny benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Booklet or is otherwise not covered under the terms of this Booklet.

Limitation of Actions

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 within 3 years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within 3 years of the appeal decision.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

- Be a full-time or qualifying part-time employee working at least 15 hours per week, member, or retiree of the Group; and
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) perform the duties of your principal occupation for the Group.

Note: For retirees who are eligible for Medicare, due to Medicare Second Payer rules, this plan may not provide primary coverage. Subscribers should compare premium and out-of-pocket costs associated with this plan to those of a Medicare Supplement plan.

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.

- The individual with whom the Subscriber has entered into a marriage recognized under the law. Throughout this Booklet, any reference to “marriage” means a lawful marriage. Any reference to “spouse” means the individual with whom the Subscriber has entered into a lawful marriage. References to legal separations apply to marriage legal separations. References to divorce apply to the termination of a lawful marriage.

- The Subscriber’s Domestic Partner. Domestic Partner means a person of the same or opposite sex who meets all of the criteria for Domestic Partnership stated in the domestic partner affidavit used by the Group.

  For purposes of this Plan, 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.

  A Domestic Partner’s or a Domestic Partner’s child’s coverage ends on the date of dissolution of the Domestic Partnership.

  Both the Subscriber and the Domestic Partner must complete and sign the domestic partner affidavit used by the Group in addition to the enrollment form. Anthem reserves the right to make the ultimate decision in determining eligibility of the Domestic Partner.

  Throughout this Booklet, any reference to “marriage” includes Domestic Partnerships as defined in this section. Any reference to “spouse” includes the individual with whom the Subscriber has entered into a Domestic Partnership. References to legal separation include Domestic Partner legal separations. References to divorce include termination of a Domestic Partnership.

- The Subscriber’s or the Subscriber’s spouse’s children by blood or by law including natural children, stepchildren, newborn and legally adopted children, children for whom you are the proposed adoptive parent and who have been placed in your care and custody during the waiting period before the

adoption becoming final and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law, and children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law. Foster children and grandchildren are not eligible for coverage unless they meet the definition of a Dependent child stated in this section.

All enrolled eligible Dependent children will continue to be covered up to the end of the month in which the child attains age 26. Coverage may be continued past the age limit in the following circumstances:

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

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

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

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse or Domestic Partner;
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

New Subscribers and Dependents

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

Members who were previously enrolled under another carrier's group health plan that is being replaced by this health plan are eligible to enroll for coverage in this plan on the Effective Date of this coverage.

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

New Spouse

You may add a new spouse to your membership. Provided that your Group and Anthem receive a completed enrollment form within 31 days of the date of marriage, coverage under this Plan will become effective on the first day of the month after receipt of the enrollment form.

If you did not enroll your new spouse within 31 days of your marriage (the initial period), you will only be able to enroll during a Special Enrollment period or Open Enrollment period as described below in this section.

Dependent Children

If you did not enroll your Dependent children within the timeframes for initial enrollment, you will only be able to enroll them during a Special Enrollment period or Open Enrollment period as described below in this section.

Newborn Children

Newborn children of an enrolled Member (the subscriber, the subscriber's covered spouse or a covered Dependent child) are covered automatically from the moment of birth for an initial 31 days from the date of birth (the initial period). No premium is charged during the initial 31-day period after the birth of a newborn.

Coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes routine nursery care for newborns and well-child screenings and other preventive care for newborns. Please see "Inpatient Hospital Care," "Maternity Services," and "Preventive Care" in the "What's Covered" Section.

In order to continue coverage after the initial 31 days:

- You should add your newborn to your membership by completing an enrollment form (obtain the form from your Group).
- Submit the enrollment form to your Group within the initial 31-day period.

After the initial 31 days of coverage, additional premium may be required.

If, at the time of your newborn's birth, you do not have a **membership type** that covers Dependent children, you must indicate on the enrollment form that you want to change your type of membership (for example, from "two person" to "family" or from "one person" to "parent / child").

If you <u>do</u> <u>not</u> want to cover the child beyond the initial 31-day period, you must notify your Group as soon as reasonably possible within the initial 31-day period.

If Anthem does not receive your enrollment form within 31 days of the child's birth, your newborn's eligibility for benefits will end at midnight on the 31st day after the date of birth and you will only be able to enroll the child during a Special Enrollment period or Open Enrollment period as described below in this section.

If your covered dependent child gives birth, your newborn grandchild is eligible for benefits for up to 31 days from the child's date of birth. You cannot add the grandchild to your membership as a covered dependent child unless you adopt or become the legal guardian of the grandchild.

Adopted Children

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

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send to Anthem the completed enrollment form within 31 days of the event (the initial period).

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an enrollment form must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and / or applicable state or federal law, to enroll your child in this Plan, Anthem will permit the child to enroll at any time without regard to any Open Enrollment limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Special Enrollment Periods

If a Subscriber or Dependent does not enroll in this Plan when they are first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Please see "Initial Enrollment" above in this section for information about when individuals are first eligible to enroll.

All enrollment changes must be made through agents or brokers registered with the SHOP Marketplace by you or your Group.

Special Enrollment is available for eligible individuals who were covered under a public or private health plan when they were first eligible to enroll in this plan, and who lost the prior coverage due to:

- Voluntary or involuntary termination of employment or eligibility, or
- Voluntary or involuntary termination of the other plan's coverage (including exhaustion of coverage under continuation laws, such as COBRA whether or not such continuation options exist), or
- When employer contributions toward the prior coverage ends, or
- Death of a spouse or divorce.

Special Enrollment is also available to enrolled Subscribers or to individuals who did not enroll when first eligible when at least one of the following occurs:

- A court order requires the Subscriber to provide health coverage for an ex-spouse or a minor child under a covered employee's plan.
- An employer offers multiple health coverages and the Subscriber elects a different plan during an Open Enrollment period.
- New dependent due to marriage. Employees and eligible dependents who are not covered under this health plan may enroll due to lawful marriage at the same time as the new spouse.
- New dependent due to birth, adoption or placement for adoption. Employees and / or spouses and other eligible dependents who are not covered under this health plan may enroll at the same time as a newborn child, adopted child or a child placed in your home as the adoptive parent during the waiting period before adoption.
- Your enrollment or non-enrollment in another qualified health plan was unintentional, inadvertent or erroneous and was a result of an error, misrepresentation, or inaction by an employee or representative of the SHOP Marketplace.
- You adequately demonstrate to the SHOP Marketplace that the health plan under which you are enrolled has substantially violated a material provision of its contract with you.

- You move and become eligible for new qualified health plans, You may enroll in a new Qualified Health Plan (QHP) as a result of a permanent move, provided that you had minimum essential coverage in effect for one or more days of the 60 days prior to the move; and you request enrollment in the new QHP within 60 days of the move.

- You are a Native American Indian, as defined by section 4 of the Indian Health Care Improvement Act, and allowed to change from one qualified health plan to another as often as once per month.

- The SHOP Marketplace determines, under federal law, that you meet other exceptional circumstances that warrant a Special Enrollment.

Medicaid and Children's Health Insurance Program Special Enrollment

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

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

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

Notifying the SHOP Marketplace of Special Enrollee Events

An employee or dependent must notify the Group or the agent or broker of the SHOP Marketplace through whom the Plan was purchased of a Special Enrollment event no later than 31 days from the date of the event. Exceptions:

- Employees or dependents that either become eligible for or lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP) have 60 days from the date of the event to notify the Group, or the agent or broker of the SHOP Marketplace through whom the Plan was purchased.

- If you permanently move and become eligible for new qualified health plans, you may enroll in a new Qualified Health Plan (QHP), provided that you had minimum essential coverage in effect for one or more days of the 60 days prior to the move; and you request enrollment in the new QHP within 60 days of the move.

If an employee or dependent does not notify the Group, or the agent or broker of the SHOP Marketplace through whom the Plan was purchased within the required timeframes, they will be able to enroll only during another Special Enrollment period or during the Group's Open Enrollment period as described below in this section.

Members who enroll during Special Enrollment are not considered Late Enrollees.

Late Enrollees

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

Open Enrollment

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

Updating Coverage and / or Removing Dependents

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

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

Failure to notify the Group or the agent or broker of the SHOP Marketplace of individuals no longer eligible for services will not obligate Anthem to pay for such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Non-discrimination

No person who is eligible to enroll will be refused enrollment based on health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or gender identity, gender, or evidence of insurability, including conditions arising out of domestic violence.

Statements and Forms

All Members must complete and submit enrollment forms, or other information pertinent to enrollment and membership that Anthem may reasonably request.

The Subscriber and any applicant age 18 or older represent that all statements made in his or her enrollment form for membership, and any enrollment forms or enrollment processes for membership of dependents, are true to the best of his or her knowledge and belief. If a Subscriber furnishes any misleading, deceptive, incomplete, fraudulent or untrue statement which is material to the acceptance of his or her enrollment, Anthem may terminate his or her enrollment under this health plan (and that of his or her spouse and dependents), provided that the termination action occurs within two years from the Subscriber's date of enrollment. No statement made, for the purpose of obtaining coverage, will void coverage unless it is written in the enrollment form and signed by you, the Subscriber.

Termination and Continuation of Coverage

Termination

Except as stated below, your coverage will remain in effect and, at your Group's option, Anthem will renew the Group Contract on a date agreed upon by Anthem and your Group. At the time of renewal, your Group or Anthem may modify the health care plan offered through your Group.

Your coverage and the coverage of your Dependents may terminate in any of the following situations:

- If you choose to terminate coverage.

- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and / or you must notify Anthem immediately. The Group and / or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify Anthem that you have elected coverage elsewhere.

- For fraud or intentional misrepresentation on the part of an individual or an individual's representative or on the part of an employer, employee, Dependent or an employee's representative.

  The Subscriber and any applicant age 18 or older represent that all statements made in his or her enrollment form for membership, and any enrollment forms or enrollment processes for membership of Dependents, are true to the best of his or her knowledge and belief.

- Anthem may not renew a Subscriber's coverage for fraud committed by the Subscriber or Member in connection with the enrollment form for this Plan or with any claim filed under this Plan.

- If a Subscriber furnishes any misleading, deceptive, incomplete, fraudulent or untrue statement which is material to the acceptance of his or her enrollment, Anthem may prospectively terminate his or her enrollment (and that of his or her spouse and Dependents), provided that the termination action occurs within two years from the Subscriber's date of enrollment. No statement made, for the purpose of obtaining coverage, will void coverage unless it is written in the enrollment form and signed by you, the Subscriber.

- The validity of this policy shall not be contested for information provided on the application after it has been in force for 2 years from its Effective Date. However, Anthem shall not be precluded from terminating a Member based upon his or her eligibility for coverage under the policy or upon other provisions in the policy.

  A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar-day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Anthem for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments, Deductible, Coinsurance or Premium paid for such services. No statement made, for the purpose of obtaining coverage, will void coverage unless it is written in the enrollment form and signed by you, the Subscriber.

- If you permit the use of your or any other Member's Plan ID Card by any other person; use another person's ID Card; or use an invalid ID Card to obtain services, coverage will terminate upon 30 days advance written notice to your Group. Anyone involved in the misuse of a Plan ID Card will be liable to and must reimburse Anthem for the Maximum Allowed Amount for services received through such misuse.

- If your Group does not pay the required Premiums or if you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium. Coverage for you and your Dependents will terminate on a date stated in a notice mailed by Anthem to the Group. Cancellation for non-payment is considered cancellation by the Group and Subscriber, and not by Anthem.

  There is a grace period of 31 days for the payment of any Premium due except the first. If, during the grace period, your Group pays the full amount owed, coverage under this health care plan will remain in effect. Your Group will be liable to pay Anthem for any portion of the Premium corresponding to the time within the grace period during which this health care plan remains in effect. This paragraph will not apply if your Group terminates coverage under this health care plan by notifying Anthem in writing of the termination before the period for which payment is due.

- If your Group does not meet Anthem's minimum employee participation requirements. A notice of cancellation or non-renewal for failure to meet minimum participation requirements will be delivered to the Group by Anthem, (or mailed to the Group's most current address, as shown on Anthem's records) at least 30 days before the effective date of the cancellation or non-renewal.

- If a small employer is no longer actively engaged in the business that it was engaged in on the effective date of this Plan.

- If the employer restricts eligibility to participate in the plan based on an applicant's medical history or otherwise violates applicable law regarding medical underwriting, such as New Hampshire law and federal HIPAA regulations,

- If Anthem ceases to offer coverage in the small and / or large employer market, and has provided 180 days prior notification to the New Hampshire Insurance Department of such action and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

Except for nonpayment of premium and as otherwise stated above in this subsection, any notice of cancellation or non-renewal will be delivered to the Group by Anthem or mailed to the Group's most current address, as shown on Anthem's records at least 45 days before the Group's renewal date.

Removal of Members

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

Special Rules if Your Group Health Plan is offered through a SHOP Marketplace

If your Plan is offered through an agent or broker registered with the SHOP Marketplace, either you or your Group may cancel your coverage and / or your Dependent's coverage through the SHOP Marketplace representatives. Each SHOP Marketplace will have rules on how to do this. You may cancel coverage by sending a written notice to either the agent or broker of the SHOP Marketplace or Anthem. The date that coverage will end will be either:

- The date that you ask for coverage to end, if you provide written notice within 14 days of that date; or

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

Continuation of Coverage Under New Hampshire Law

New Hampshire law allows you to continue coverage when group coverage would otherwise end.

Continuation for Divorce or Legal Separation

If you and your spouse are divorced or legally separated while you are a member of a Group Health Plan, your former spouse is eligible to remain on your policy, as an active dependent until the earliest of the following events occurs:

- Remarriage of the Subscriber;
- Remarriage of the former spouse;
- Death of the Subscriber;
- The 3-year anniversary of the final decree of divorce or legal separation; or
- Such earlier time as provided by the final divorce decree or legal separation.

NOTE: If the covered divorced or legally separated spouse is 55 years old or older, the former spouse may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after the date of the divorce or legal separation, *whichever occurs first.*

When one of the above events occurs, your Group Benefits Administrator must notify Anthem of your former spouse's ineligibility. Your former spouse may be eligible under the State of New Hampshire Continuation provisions described below in "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End."

If your Group replaces this coverage with another insurance carrier, your former spouse may be eligible to continue as your active dependent under the replacement policy. Please consult with the replacement carrier for complete information.

New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End

This subsection applies if you experience a Continuation Event.

- You are not an eligible employee or dependent if you were not covered under the group plan at the time of the Continuation Event.

- You are not an eligible employee or dependent if you are eligible for other group coverage or you are enrolled in Medicare when a Continuation Event occurs. If you are entitled to Medicare but not enrolled for Medicare benefits at the time of a Continuation Event, you should contact your local Social Security Office immediately for assistance because *continuation ends on the first day that you become eligible for Medicare.* For the purposes of this article, "eligible for Medicare" means that you are entitled to enroll in Medicare:

    - On a date outside the Medicare open enrollment period without application of the Medicare penalty for late enrollment, or

    - On a date during an open enrollment period, *whichever date occurs first.*

Continuation Events - Eligible employees and their eligible dependents can elect to continue group coverage under NH law when one of the following events occurs:

- Your employment is terminated for any reason (except gross misconduct),

- Your hours of employment are reduced so that you no longer qualify to participate in your employer health care plan,

- Coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, or

- The eligible employee dies.

Eligible dependents can elect to continue group coverage when one of the following events occurs:

- A dependent child no longer meets Anthem's definition of a dependent child or incapacitated child,

- You (the ex-employee) and your dependents are on an 18-month continuation period and your continuation ends because you enroll in Medicare or you become eligible for Medicare following a Continuation Event.

Continuation Periods - You and your covered dependents may continue coverage for up to 18 months if:

- Your employment is terminated for any reason (except gross misconduct), or

- Your hours of employment are reduced so that you no longer qualify to participate in your group's health care plan.

You may continue coverage for up to 29 months if you are disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of a continuation period. (Medicare begins coverage for the disabled at 29 months.) For ease of administration, you should contact your Group and Anthem as soon as possible after you are notified of your disability status by the Social Security Administration.

Your covered surviving spouse may continue coverage for up to 36 months if coverage would otherwise end because of your death. If your surviving spouse is 55 years old or older, he or she may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after your death, *whichever occurs first.*

Your covered spouse may continue coverage for up to 36 months if coverage would otherwise end because your spouse is on an 18-month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

Your covered dependent may continue coverage for up to 36 months if coverage would otherwise end because:

- The child no longer meets Anthem's definition of a covered dependent child, or

- Because of your death, or

- The child is on an 18-month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

- Substantial loss of coverage by retirees and dependents within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.

Note: If any of the above events occur during an 18-month continuation period, the time spent on the 18-month period counts toward a total of 36 months of continued coverage for your child.

Notifications - Within 30 days of receiving notice from your Group's Benefit Administrator that you and / or your covered dependent(s) became ineligible for coverage under your group health benefit plan, you and / or your covered dependent(s) will receive a letter from Anthem notifying you and / or your covered dependent(s) of your right to elect to continue coverage.
Anthem's letter will contain information about your right to continue coverage, the amount of premium required to continue coverage and the procedure for electing continuation coverage. You will have 45 days from the date of Anthem's letter to make your election by:

- Notifying Anthem of your election in writing, and

- Sending a copy of your election notice to your Group.

Continuation Premium - The premium for continued coverage will not be more than 102 percent of the premium charged for employees with similar coverage. The initial premium payment must be paid to your employer at the same time as you submit your initial election of coverage. You must pay subsequent premiums and the administrative fee to your employer by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Continuation Ends - Continuation of group coverage ends on the earlier of one of the following events:

- You become eligible for other group coverage (if you enroll in another group health care plan which contains preexisting condition or waiting period limitations, you may continue coverage only until such limitations cease),
- You enroll in Medicare or on the date that you first become eligible for Medicare following a Continuation Event,
- You do not pay the required premium and administrative fee on time, or your employer (or the insurer) terminates all health benefits for all employees.
- The legal time period of your Continuation Event has expired.

Termination of the Entire Group Health Plan (39-Week Extension)

Termination of the entire group health plan (39-week) - If an employer sponsored group health care plan is terminated for all employees for any reason, members who are covered at the time of such termination may elect to continue the benefits of the plan at the same group rate (plus a two percent administrative fee) as follows:

- For up to 39 weeks (NOTE: where an individual is already on a continuation coverage, coverage shall continue until it would have expired had the plan not been terminated or for 39 weeks, whichever occurs first.),
- Until the required premium is not paid on time, or
- Until the continuing member becomes eligible for benefits under another group plan (including Medicare), *whichever event occurs first.*

Exception: If you enroll in another group health benefit plan while you are continuing coverage under this statute and the new plan contains preexisting condition or waiting period exclusions or limitations, you may continue coverage under this statute only until such limitations cease.

(If your Group canceled coverage with Anthem for all employees because the Group contracted for coverage with another carrier, you are always considered to be eligible for coverage under the new plan and you are not eligible to continue coverage.)

Anthem will send you a written notice explaining your right to continue coverage under this statute within 30 days of the date your group coverage terminated. Our notice will include information about the conditions of coverage and the premiums that you must pay in order to continue coverage. The election period is a period of 31 days from the date of Anthem's notice. To elect the 39-week extension, you must do both of the following with the election period.

- Notify Anthem in writing that you elect to continue coverage under this statute, and
- Provide the first monthly premium (plus a two percent administrative fee).

Note: Our written notice will be presented to you or mailed to you. If mailed, we will use the most current address on file at our office. Provided that you notify us in writing within this additional period and provided that you submit the required payment with your notification, the effective date of your continuation under this law is the group's cancellation date. (You are responsible for making payments as billed by Anthem for your extension of group coverage under this law. You are not responsible for paying Anthem for any premiums that were the Group's responsibility prior to the Group's cancellation date.)

After we receive your written notice of election (and your premium payment plus a two percent administration fee), Anthem will bill you for subsequent payments. You must pay the required premium and administrative fee to Anthem by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. Anthem will notify you within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Strike, Lockout or Other Labor Dispute

If your Group pays part or all of the premiums required to maintain coverage under this Booklet and your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, you the employee may maintain coverage under this Booklet for up to 6 months from the date your compensation is suspended. You must make premium payments on time directly to your Group during the 6-month period. Your Group must remit your payments to Anthem by the due date, as shown on Anthem's invoice issued to your Group.

During the 6-month period, your Group coverage cannot be altered or changed except for modifications that can occur upon expiration and renewal of your Group plan and the decreases or increases of the premium rate upon renewal.

Under New Hampshire law, your Group is required to notify you in writing immediately upon suspension or termination of your compensation as the result of a strike, lockout or other labor dispute. Notice must be sent by mail to the address last on record with your Group.

Eligibility for coverage under this subsection ends when the earliest of the following events occurs:

- You become a full-time employee with another employer, or
- Your premiums are not remitted when due. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period, or
- 6 months after your compensation is suspended or terminated as the result of a strike, lockout or other labor dispute.

After the 6-month period ends, you, the employee may continue coverage under this Booklet for an additional 12 months as if you originally had elected the rights provided under "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End" (above) and subject to the same conditions stated in "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End."

Continuation of Coverage Due To Military Service

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

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

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
    - The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
    - 14 days after completing military service for leaves of 31 to 180 days;
    - 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

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

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

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

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

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before as if you had been continually covered under the Plan from your original Effective Date.

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

Individual Insurance Offered by Anthem

When a continuation of Group coverage ends, you shall have the right to convert to an individual policy offered by Anthem.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave of absence under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being at work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must give evidence satisfactory to Anthem of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

Extension of Benefits Due To Total Disability

New Hampshire regulations provide extension rights for Members with continuous Total Disabilities, even if a Member does not elect to continue coverage as otherwise described in this section.

You are entitled to an extension of the benefits described in this Booklet when:

- Your group coverage with Anthem ends, and
- You have a continuous Total Disability on the termination date.

If you are entitled to benefits for a continuous Total Disability existing on the cancellation date, benefits for that disability will be allowed for up to 12 months beyond the Group's date of cancellation.

Your eligibility for an extension of benefits for a continuous Total Disability ends when:

- The 12-month continuous Total Disability period ends, or
- Your continuous Total Disability ends, or
- You reach the limit of benefits available to you under your Booklet, *whichever event occurs first.*

A Member has a continuous Total Disability if:

- The Member is totally disabled from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and
- The Member is not engaged in any employment or occupation for wage or profit.

You (or someone acting for you) must notify Anthem that you qualify for an extension of benefits due to Total Disability. To do so, please call Member Services at 1-855-748-1805 for assistance.

Total Disability extensions are not available for services connected to dental expenses.

Health Insurance Marketplace

There may be other coverage options for you and your family through the Health Insurance Marketplace www.HealthCare.gov. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your Premium, Deductibles, and out-of-pocket

costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

General Provisions

Assignment

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

Care Coordination

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

Clerical Error

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

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 https://www.anthem.com/privacy and can be furnished to you upon request by contacting our Member Services department at 1-855-748-1805.

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

Conformity with Law

Any term of the Plan which is in conflict with New Hampshire law or with applicable federal laws will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of New Hampshire. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and / or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has

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

Entire Contract

The laws of New Hampshire will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual enrollment forms of the Subscriber and Dependents constitute the entire contract between the Group and Anthem and as of the Effective Date, supersede all other agreements. Any and all statements made to Anthem by the Group and any and all statements made to the Group by Anthem are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

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

Medical Policy and Technology Assessment

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

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

Medicare

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

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services.

Member Rights and Responsibilities

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

It can be found on our website FAQs. To access, go to https://www.anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect

You" category. Then click on the "What are my rights as a member?" question. 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 1-855-748-1805.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and Anthem without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice Anthem gives to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

No agent has the authority to change or waive any of the provisions of this Booklet. No change in the Booklet shall be valid unless approved by Anthem's chief executive in New Hampshire and evidenced by amendment to the Booklet or by amendment to the Booklet signed by the Subscriber and Anthem.

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

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

Under the terms of the Group Contract, Anthem has the authority, in its 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 which may result in the payment of benefits not otherwise specified in this Booklet. Anthem reserves the right to discontinue a pilot or test program at any time. Anthem will give 30 days advance written notice to the Group of the introduction or termination of any such program.

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 require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.

Relationship of Parties (Group-Member-Anthem)

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. The Right of Recovery may result in an adjustment to the claim. 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. In most instances recovery or adjustment activity will occur within 12 months of the date of a payment made. Recovery or adjustment can occur beyond 12 months in certain circumstances when, for example - but not limited to, the claim payment was made incorrectly, the healthcare was not delivered by the provider or the claim was submitted fraudulently. Lastly, we will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card (ID Card)

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

Value of Covered Services

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

Waiver

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

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. If Anthem pays benefits for services you receive, all money paid or owed by Workers' Compensation for your services shall be paid back to Anthem by you or on your behalf. It is

understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you need additional clarification on any of these definitions, please contact Member Services at 1-855-748-1805.

Accidental Injury

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

Adverse Determination

A decision by Anthem (or by a designated clinical review entity of Anthem) that a scheduled or emergency admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem's definition of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, benefits are denied, reduced or terminated by Anthem.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and is approved by us.

Anthem

Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem). Anthem is a stock corporation and licensed Accident and Health insurer in the State of New Hampshire.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that Anthem has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and / or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Benefit Period

The length of time Anthem will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (Please see your Group for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

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

Biosimilar / Biosimilars

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

Birthing Center

An outpatient Facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide outpatient Facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn.

To be eligible for benefits under this Booklet, a Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no benefits are available for services furnished by a Birthing Center.

BlueCard® Provider

A Provider outside New Hampshire that is not an In-Network Provider, but has a written payment agreement with the local Blue Cross and Blue Shield Plan.

Booklet

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

Brand Name Drugs

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

Calendar Year

A Benefit Period that starts on January 1st and ends on December 31st.

Claim Denial

Any of the following: Anthem's denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member's eligibility for coverage under this Booklet. Claim Denial also includes Anthem's denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of utilization review procedures, as well as failure to cover a service for which benefits are otherwise provided based on a determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. Please see the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Community Mental Health Center

A licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963 or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

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

Copayment

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

Covered Services

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

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

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

The date for applying Deductible and other cost shares for Inpatient Facility charges is the date you enter the Facility.

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

Custodial Care

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

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

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

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

Deductible

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

Dentally Necessary Orthodontic Care

A service for Members used to treat malocclusion of teeth and associated dental and facial disharmonies. The Dentally Necessary Orthodontic Care criteria are listed in the "Dental Services For Members Through Age 18" section under "Orthodontic Care" Please refer to this section for detailed information.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment-Adding Members" section and who has enrolled in the Plan.

Designated Pharmacy Provider

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

Diabetes Education Provider

A certified, registered or licensed health care expert in diabetes management.

Doctor

Please see the definition of "Physician."

Domestic Partner

A person of the same or opposite sex who meets all of the criteria for Domestic Partnership stated in the domestic partner affidavit used by your Group.

Effective Date

The date that your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

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

Emergency Care

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

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational

Anthem will not pay for Experimental or Investigational Services. Except as stated in the "What's Covered" section, "Clinical Trials," no benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental or Investigational Services. No benefits are available for care furnished for complications arising from Experimental or Investigational Services.

"Experimental or Investigational Service" means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

A drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:

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

A service that is not Experimental or Investigational based on the above criteria may still be Experimental or Investigational if:

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
- The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

When applying the above provisions to the administration of benefits under this health plan, Anthem may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and / or filed with the FDA or other federal, state or local agency with the

authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- The written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

Anthem uses the terms of this subsection in reviewing services that may be Experimental or Investigational. Anthem's medical policy assists in Anthem's review. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the benefits, exclusions and limitations stated in this Booklet take precedence over medical policy.

You have the right to appeal benefit determinations made by Anthem, including Adverse Determinations regarding Experimental / Investigational Services. For complete information about the appeal process, please see the "Member Satisfaction Services, Appeals and External Review" section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Birthing Center, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements and be approved by us.

Generic Drugs

Prescription Drugs that the FDA has classified as Generic Drugs. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

An organization (such as a large employer, or small employer) to which you belong, that arranges for your coverage as described in this Booklet.

Group Benefits Administrator

The person at your company or place of employment who handles health benefits for your Group.

Group Contract (or Contract)

The Contract between Anthem and the Group. It includes this Booklet, your enrollment form, any enrollment or change form, your ID Card, any endorsements, riders or amendments, and any legal terms added by Anthem to the original Contract.

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

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

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

Hospice

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

Hospital

A facility licensed as a Hospital as required by law that satisfies our accreditation requirements and is 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)

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

Infertility

Infertility, which may occur in either male or female, means the inability to become pregnant or to carry a pregnancy to live birth, or the inability to cause pregnancy and live birth, in accordance with guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology.

Male infertility may include but is not limited to blockage of the seminal tract, a congenital absence or congenital obstruction of the vas deferens, or low sperm motility or quantity Please note that menopause in a woman is considered a natural condition and is not considered "Infertility" as defined in this Booklet.

In-Network Provider

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

Inpatient

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

Intensive In-Home Behavioral Health Program

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

Intensive Outpatient Program

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

Interchangeable Biologic Product

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

Late Enrollees

Subscribers or Dependents who request enrollment in the Plan after the initial enrollment period. An individual will not be considered a Late Enrollee if the person enrolls during a Special Enrollment period. Please refer to the "Eligibility and Enrollment – Adding Members" section for further details.

Maintenance Medications

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.

Maintenance Pharmacy

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

Maximum Allowed Amount

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

Medical Director

A Physician licensed under New Hampshire law, who is employed by Anthem and is responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medical Necessity (Medically Necessary)

Health care services or products provided to an enrollee for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the enrollee or the Provider.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting.

Please note: The fact that a Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and / or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

You have the right to appeal benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding Medical Necessity. For complete information about the appeal process, please see the "Member Satisfaction Services, Appeals and External Review Procedures" section.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, completed the enrollment process, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Use Disorders

A Mental Disorder is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. This term does not include chemical dependency such as alcoholism. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

Mental Disorders include:

- Schizophrenia and other psychotic disorders such as, but not limited to, paranoia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Obsessive compulsive disorder
- Pediatric autoimmune neuropsychiatric disorders
- Panic disorder
- Anorexia nervosa
- Bulimia nervosa and
- Chronic post-traumatic stress disorder

Pervasive developmental disorders or autism are Mental Disorders. Pervasive developmental disorders are defined in the most current version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association to include autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

A Substance Use Disorder is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and / or other drugs in such a manner that his or her health is impaired and / or ability to control actions is lost. Nicotine addiction is not a Substance Use Disorder under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Use Disorder, Anthem will refer to the most current edition of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association and may also refer to the International Classification of Diseases (ICD) Manual.

New Hampshire Certified Midwife

An individual who is a certified midwife under New Hampshire law.

Open Enrollment

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

Out-of-Network Provider

A Provider that does not have an agreement or contract with Anthem or Anthem's subcontractor(s) to give services to our Members. You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

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

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 Benefits Manager (PBM)

A Pharmacy benefit management company that manages Pharmacy benefits on Anthem's behalf. CarelonRx, Anthem's PBM, has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. CarelonRx, 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.

Pharmacy and Therapeutics (P&T) Process

The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality, affordable medications within the pharmacy benefit plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to discuss and determine clinical and financial value of medications for Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with a thorough review of the market dynamics, member impact and financial value to make decisions for the formulary. Anthem's programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physical Rehabilitation Facility

A state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Physician (Doctor)

Includes the following when licensed by law:

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

Optometrists, Psychologists (PhD), Doctors of Naturopathic Medicine and Advanced Practice Registered Nurses (APRN) are also Physicians (Doctors) when legally licensed and giving Covered Services within the scope of their licenses.

Plan

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

Plan Year

A Benefit Period that starts on your Group's effective or renewal date and lasts for 12 months.

Post-Service Claim

Any claim for a health benefit to which the terms of the plan do not condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care or disability benefit. "Post-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Pre-Service Claim

Any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Precertification

A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date.

Premium

The amount that you and / or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us. Premium rates accepted by your Group at initial enrollment or at the Group's annual renewal are guaranteed for 12 months from the effective date of the Group's coverage. Premium rates may change if your Group changes the plan offered to employees or on the date of your Group's annual renewal. Anthem will notify your Group of any renewal premium increase at least 60 days before your Group's annual renewal date.

Prescription Drug (Drug)

A substance that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1) Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, including diabetic needles and syringes.

Prescription Order (Prescription)

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

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

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

Private or Public Hospital

A licensed Private Psychiatric Hospital or Public Mental Health Hospital that provides diagnostic services, treatment and care of acute mental illnesses under the care of a staff of Physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers, is 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 Covered Services. Providers that deliver Covered Services are described throughout this Booklet. This also may include unlicensed behavior health Providers as permitted by law and that meet the criteria as described in this Booklet. If you have a question about a Provider not described in this Booklet, please call the number on the back of your ID Card 1-855-748-1805.

Psychiatric Advanced Practice Registered Nurse

A professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, except where otherwise required by law the Recognized Amount is the lesser of the amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act, the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic

area where the service is provided for the same or similar services), or the amount billed by the Out-of-Network Provider or Out-of-Network Facility.

Referral

A specific recommendation by a Member's Provider 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 Provider on the written Referral form or by other notification methods prescribed by Anthem for use by Providers. A general statement by a Provider that a Member should seek a particular type of service or Provider does not constitute a Referral under this Booklet.

Residential Treatment Center / Facility

An Inpatient Facility that treats Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

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

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Advanced Practice Registered Nurses.

Service Area

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

Short Term General Hospital

A health care institution having an organized professional and medical staff and Inpatient Facilities that care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

Site of Service Provider

Site-of-Service (SOS) Providers can be labs, radiology and imaging centers that meet cost and other criteria established by Anthem. They are:

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

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

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

Skilled Nursing Facility

A facility licensed as a skilled nursing facility in the state in which it is located that satisfies our accreditation requirements and is 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.

Special Enrollment

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

Specialist (Specialty Care Physician / Provider or SCP)

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

Specialty Drugs

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

Subscriber

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

Surprise Billing Claim

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Substance Use Disorder Services

Health care services that are provided to a Member as treatment for an addictive substance-related condition, not including treatment for any condition related to tobacco use.

Substance Use Disorder Treatment Provider

A Facility that is approved by Anthem and which meets the following criteria: is licensed, certified or approved by the state where located to provide substance use disorder rehabilitation, and is affiliated with a Hospital under a contractual agreement with an established patient referral system, or is accredited by the Joint Commission on Accreditation of a Hospital as a Substance Use Disorder Treatment Provider.

Urgent Care Center

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

Urgent Care Claim

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or

- In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

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.

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 1-855-748-1805 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.

Get help in your language

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID Card for help (TTY / TDD: 711).

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID Card 1-855-748-1805.

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)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (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)

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)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY / TDD: 711)

Haitian
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)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY / TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY / TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY / TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क पर्‌ा गन तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID काडर्‌मा दिइएको सदस्‌य सेवा नम्‌बरमा कल गनुर्‌होस्‌। (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY / TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY / TDD: 711)

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)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY / TDD: 711)

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)

NH EPO / PPO Mandate Booklet

12934NH Rev 01.01.2024

Anthem BlueCross BlueShield

NH EPO / PPO Mandate Booklet

This booklet is issued for attachment to, and becomes a part of, the Certificate of Coverage.

Contents

Anthem Blue Cross and Blue Shield
1155 Elm Street, Suite 200
Manchester, NH 03101-1505

Anthem's toll-free telephone number is on your Identification Card (1-855-748-1805).

Maria M. Proulx

Maria M. Proulx
President and General Manager
New Hampshire

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

CONSUMER GUIDE TO EXTERNAL APPEAL

What is an External Appeal?

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. This type of review is available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This review is often called Independent External Appeal, **External Appeal**, External Health Review or simply External Review.

What are the eligibility requirements for External Appeal?

To be eligible for External Appeal the following conditions must be met:

- The patient must have a fully-insured health or dental insurance plan.
- The service that is the subject of the appeal request must be either a) a covered benefit under the terms of the insurance policy or b) a treatment that may be a covered benefit.
- Unless the patient meets the requirements for Expedited External Review (see below), the patient must have completed the Internal Appeal process provided by the insurer and have received a final, written decision from the insurer relative to its review.
  - Exception #1: The patient does not need to meet this requirement, if the insurer agrees in writing to allow the patient to skip its Internal Appeal process.
  - Exception #2: If the patient requested an internal appeal from the insurer, but has not received a decision from the insurer within the required time frame, the patient may apply for External Appeal without having received the insurer's final, written decision.
- The patient must submit the request for External Appeal to the Department within 180 days from the date appearing on the insurance company's letter, denying the requested treatment or service at the final level of the company's Internal Appeals process.
- The patient's request for External Appeal may not be submitted for the purpose of pursuing a claim or allegation of healthcare provider malpractice, professional negligence, or other professional fault.

What types of health insurance are excluded from External Appeal?

In general, External Appeal is available for most health insurance coverage. Service denials relating to the following types of insurance coverage or health benefit programs are not reviewable under New Hampshire's External Appeal law:

- Medicaid (except for coverage provided under the NH Premium Assistance Program)
- The New Hampshire Children's Health Insurance Program (CHIP)
- Medicare
- All other government-sponsored health insurance or health services programs.
- Health benefit plans that are self-funded by employers
  - Note: Some self-funded plans provide external appeal rights which are administered by the employer.

Can someone else represent me in my External Appeal?

Yes. A patient may designate an individual, including the treating health care provider, as his/her representative. To designate a representative, the patient must complete Section II of the External Review Application Form entitled "Appointment of Authorized Representative."

Submitting the External Appeal:

To request an External Appeal, the patient or the designated representative must complete and submit the External Review Application Form, available on the Department's website (www.nh.gov/insurance), and all supporting documentation to the New Hampshire Insurance Department. There is no cost to the patient for an External Appeal.

Please submit the following documentation:

- ☐ The completed External Review Application Form - signed and dated on page 6.
  **** The Department cannot process this application without the required signature(s) ****
- ☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the insurance company named in the appeal.
- ☐ A copy of the insurance company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the review organization to consider in its review.
- ☐ If requesting an Expedited External Appeal, the Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review Applications

- May be faxed to (603) 271-1406, or
- Sent by overnight carrier to the Department's mailing address.

What is the Standard External Appeal Process and Time Frame for receiving a Decision?

It may take up to 60 days for the Independent Review Organization (IRO) to issue a decision in a Standard External Appeal.

I. Within 7 business days after receiving your application form, the Insurance Department (the Department) will complete a preliminary review of your application to determine whether your request is complete and whether the case is eligible for external review.

- If the request is not complete, the Department will inform the applicant what information or documents are needed in order to process the application. The applicant will have 10 calendar days to supply the required information or documents.

II. If the request for external appeal is accepted, the Department will select and assign an IRO to conduct the external review and will provide a written notice of the acceptance and assignment to the applicant and the insurer.

III. Within 10 calendar days after assigning your case to an IRO, the insurer must provide the applicant and the IRO a copy of all information in its possession relevant to the appeal.

IV. If desired, the applicant may submit additional information to the IRO by the 20th calendar day after the date the case was assigned to the selected IRO. During this period, the applicant may also present oral testimony via telephone conference to the IRO. However, oral testimony will be permitted only in cases where the Insurance Commissioner determines that it would not be feasible or appropriate to present only written information.

- To request a "teleconference," complete Section VII of the application form entitled "Request for a Telephone Conference" or contact the Department no later than 10 days after receiving notice of the acceptance of the appeal.

V. By the 40th calendar day after the date the case was assigned to the selected Independent Review Organization, the IRO shall a) review all of the information and documents received, b) render a decision upholding or reversing the determination of the insurer, and c) notify in writing the applicant and the insurer of the IRO's review decision.

What is an Expedited External Appeal?

Whereas a Standard External Appeal may take 60 days, Expedited External Appeal is available for those persons who would be significantly harmed by having to wait. An applicant may request expedited review by checking the appropriate box on the External Review Application Form and by providing a Provider's Certification Form, in which the treating provider attests that in his/her medical opinion adherence to the time frame for standard review would seriously jeopardize the patient's life or health or would jeopardize the patient's ability to regain maximum function. Expedited reviews must be completed in 72 hours.

If the applicant is pursuing an internal appeal with the insurer and anticipates requesting an Expedited External Appeal, please call the Department at 800-852-3416 to speak with a consumer services officer, so that accommodations may be made to receive and process the expedited request as quickly as possible.

Please note a patient has the right to request an Expedited External Appeal simultaneously with the insurer's Expedited Internal Appeal.

What happens when the Independent Review Organization makes its decision?

- If the appeal was an Expedited External Appeal, in most cases the applicant and insurer will be notified of the IRO's decision immediately by telephone or fax. Written notification will follow.
- If the appeal was a Standard External Appeal, the applicant and insurer will be notified in writing.
- The IRO's decision is binding on the insurer and is enforceable by the Insurance Department. The decision is also binding on the patient except that it does not prevent the patient from pursuing other remedies through the courts under federal or state law.

Have a question or need assistance?

Staff at the Insurance Department is available to help.

Call 800-852-3416 to speak with a consumer services officer.

The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14; Concord, NH 03301
Tel.: (603) 271-2261 Fax: (603) 271-1406 TDD Access Relay NH: 1-800-735-2964

INDEPENDENT EXTERNAL REVIEW

Appealing a Denied Medical or Dental Claim

New Hampshire law gives individuals who are covered by fully-insured, health or dental insurance plans the right to have a nationally-accredited, independent, medical review organization (IRO), which is not affiliated with his/her health insurance company, review and assess whether the company's denial of a specific claim or requested service or treatment is justified. These reviews are available when a recommended service or treatment is denied on the basis that it does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. This review is called Independent External Appeal, External Health Review or simply **External Review**.

There is no cost to the patient for an external review.

To be eligible for **Standard External Review**, the patient must (1) have a fully-insured health or dental insurance plan, (2) have completed the insurer's internal appeal process, and (3) have received a final denial of services from the insurer. A standard external review must be submitted to the Insurance Department within 180 days of the insurance company's final denial and may take up to 60 days for the IRO to make its decision.

To be eligible for **Expedited External Review**, the patient must (1) have a fully-insured health or dental insurance plan, and (2) the treating provider must certify that delaying treatment will seriously jeopardize the life or health of the patient or will jeopardize the patient's ability to regain maximum function. IROs must complete expedited reviews within 72 hours. An expedited external review may be requested and processed at the same time the patient pursues an expedited internal appeal directly with the insurance company.

For more information about external reviews, see the Insurance Department's Consumer Guide to External Review, available at www.nh.gov/insurance, or call 800-852-3416 to speak with a Consumer Services Officer.

Have a question or need assistance?

Staff at the Insurance Department is available to help.
Call 800-852-3416 to speak with a consumer services officer.

SUBMITTING A REQUEST FOR EXTERNAL REVIEW

To request an external review, please provide the following documents to the New Hampshire Insurance Department at the address below:

- ☐ The enclosed, completed application form - signed and dated on page 6.
  **** The Department cannot process this application without the required signature(s) ****
- ☐ A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- ☐ A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- ☐ Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- ☐ If requesting an Expedited External Review, the treating Provider's Certification Form.

If you have questions about the application process or the documentation listed above, please call the Insurance Department at 1-800-852-3416.

Mailing Address:

New Hampshire Insurance Department
Attn: External Review Unit
21 South Fruit Street, Suite 14
Concord, NH 03301

Expedited External Review applications may be faxed to (603) 271-1406 or sent by overnight carrier to the address above. If you wish to email the application package, please call the Insurance Department at 1-800-852-3416.

The State of New Hampshire
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21 South Fruit Street, Suite 14; Concord, NH 03301
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EXTERNAL REVIEW APPLICATION FORM

Request for Independent External Appeal of a Denied Medical or Dental Claim

Section I – Applicant Information

Patient's Name:_____ Patient's Date of Birth: _____

Applicant's Name:_____Applicant's Email: _____

Applicant's Mailing Address: _____

City: _____State:_____Zip Code: _____

Applicant's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section II – Appointment of Authorized Representative

**** Complete this section, only if someone else is representing the patient in this appeal ****

You may represent yourself or you may ask another person, including your treating health care provider, to act as your personal representative. You may revoke this authorization at any time.

I hereby authorize_____to pursue my appeal on my behalf.

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

Representative's Mailing Address: _____

City:_____State:_____Zip Code: _____

Representative's Phone Number(s): Daytime: (_____)_____ Evening: (_____)_____

Section III - Insurance Plan Information

Member's Name:_____Relationship to Patient: _____

Member's Insurance ID #:_____Claim/Reference #: _____

Health Insurance Company's Name: _____

Insurance Company's Mailing Address: _____

City:_____State:_____ Zip Code: _____

Insurance Company's Phone Number: (_____) _____

Name of Insurance Company representative handling appeal: _____

Is the member's insurance plan provided by an employer? Yes _____ No ____

- Name of employer: _
- Employer's Phone Number: (_____) _____
- Is the employer's insurance plan self-funded? Yes* _____ No ____

*** If you are not certain, please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may provide external review, but may have different procedures.**

New Hampshire Premium Assistance Program

Is the patient's health insurance provided through the Medicaid Premium Assistance Program, which is administered by the NH Department of Health and Human Services?

Yes_____No _____

If yes, please provide the Medicaid ID number & complete the following records release:

Medicaid ID Number: _

I,_____, hereby authorize the New Hampshire Insurance Department to release my external review file to the New Hampshire Department of Health and Human Services (DHHS), if I request a Medicaid Fair Hearing following my independent external review. I understand that DHHS will use this information to make a Fair Hearing determination and that the information will be held confidential.

Section IV – Information about the Patient's Health Care Providers

Name of Primary Care Provider (PCP): _____

PCP's Mailing Address: _____

City:_____State:_____Zip Code: _____

PCP's Phone Number: ( ) _____

Name of Treating Health Care Provider: _____

Provider's clinical specialty: _____

Treating Provider's Mailing Address: _____

City:_____State:_____Zip Code: _____

Treating Provider's Phone Number: (_____) _____

Section V – Health Care Decision in Dispute

Describe the health insurer company's decision in your own words. Include any information you have about the health care services, supplies or drugs being denied, including dates of service or treatment and names of health care providers. Explain why you disagree.

Please attach the following:

- Additional pages, if necessary;
- Pertinent medical records;
- If possible, a statement from the treating health care provider indicating why the disputed service, supply, or drug is medically necessary.

_____

_____

_____

_____

_____

_____

_____

_____

Continued on next page

Section VI – Expedited Review

**** Complete this section, only if you would like to request expedited review ****

The patient may request that the external review be handled on an expedited basis. To request expedited review, the treating health care provider must complete the attached Provider Certification Form, certifying that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Do you request an expedited review? Yes_____No _____

Applications for Expedited External Review may be faxed to (603) 271-1406 or sent by overnight carrier to the address on the top of this form. To email the appeal, please call the Insurance Department at 1-800-852-3416 for additional instructions.

Section VII – Request for a Telephone Conference

**** Complete this section, only if you would like to request a telephone conference ****

If the patient, the authorized representative or the treating health care provider would like to discuss this case with the Independent Review Organization and the insurer in a telephone conference, select "Yes" below and explain why you think it is important to be allowed to speak about the case. If you do not request a telephone conference, the reviewer will base its decision on the written information only. The request for a telephone conference will be granted only if there is a good reason why the written information would not be sufficient.

**** Telephone conferences often cannot be completed within the timeframe for expedited reviews ****

Do you request a telephone conference? Yes_____No _____

My reason for requesting a phone conference is:

VIII – Authorization and Release of Medical Records

I,_____, hereby request an external review and authorize the patient's insurance company and the patient's health care providers to release all relevant medical or treatment records to the Independent Review Organization (IRO) and the New Hampshire Insurance Department. I understand that the IRO and the Department will use this information to make a determination to either reverse or uphold the insurer's denial. I also understand that the information will be kept confidential. I further understand that neither the Commissioner nor the IRO may authorize services in excess of those covered by the patient's health care plan. This release is valid for one year.

Sign Here

_____ _____

Signature of Enrollee (or legal representative – Please specify relationship or title) Date

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Before submitting this application, please verify that you have …

☐ Completed all relevant sections of the External Review Application Form
- If appointing an authorized representative, the patient must complete Section II.
- If requesting an Expedited External Review, Section VI must be completed and the Provider Certification Form must be submitted.
- If requesting a telephone conference, Section VII must be completed.

☐ Signed and dated the External Review Application Form in Section VIII.

☐ Attached the following documents:
- A photocopy of the front and back of the patient's insurance card or other evidence that the patient is insured by the health or dental insurance company named in the appeal.
- A copy of the Health Insurance Company's letter, denying the requested treatment or service at the final level of the company's internal appeals process.
- Any medical records, statements from the treating health care provider(s) or other information that you would like the Independent Review Organization to consider in its review.
- If requesting an Expedited External Review, the treating Provider's Certification Form.

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PROVIDER'S CERTIFICATION FORM

For Expedited Consideration of a Patient's External Review

NOTE TO THE TREATING HEALTH CARE PROVIDER

The New Hampshire Insurance Department administers the external review process for all fully-insured health and dental plans in New Hampshire. A patient may submit an application for External Review, when his/her health or dental insurer has denied a health care service or treatment, including a prescription, on the basis that the requested treatment or service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

The time frame for receiving a decision from an Independent Review Organization (IRO) for a Standard External Review is up to 60 days. Expedited External Review is available, ***only if*** the patient's treating health care provider certifies that, in his/her professional judgment, adherence to the time frame for standard review ***would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.*** The time frame for receiving a decision from an IRO for an Expedited External Review is within 72 hours. An Expedited External Review may be requested and processed at the same time the patient pursues an Expedited Internal Appeal directly with the insurance company.

**** Expedited External Review is not available, when services have already been rendered ****

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City:_____State:_____Zip Code:_____

Phone Number: (_____)_____Fax Number: (_____)_____

Email Address: _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

PROVIDER CERTIFICATION

I hereby certify that I am a treating health care provider for _____ (hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard review of the patient's external review would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that for this reason, the patient's appeal of the denial by the patient's health insurer of requested medical services should be processed on an expedited basis.

I am aware that the Independent Review Organization (IRO) may need to contact me during non-business hours for medical information and that a decision will be made by the IRO within 72 hours of receiving this Expedited External Review request, regardless of whether or not I provide medical information to the IRO.

During non-business hours I may be reached at: (_____)_____.

I certify that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date

PATIENTS' BILL OF RIGHTS

Legislation requires that all insurers provide each new subscriber who is a resident of New Hampshire a copy of the patient's bill of rights law under NH RSA 151:21.

151:21. Patients' Bill of Rights

The policy describing the rights and responsibilities of each patient admitted to a facility, except those admitted by a home health care provider, shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments, the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by Medicare or Medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only.

For the purposes of this paragraph "health care provider" means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for non-payment for the patient's stay, except as prohibited by title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints

may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request.

The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients.
The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of age, sex, gender identity, sexual orientation, race, color, marital status, familial status, disability, religion, national origin, source of income, source of payment, or profession.

XVII. The patient shall be entitled to be treated by the patient's physician of choice subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, unmarried partner, or a personal representative chosen by the patient, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on Medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

XXII. The patient shall not be denied admission, care, or services based solely on the patient's vaccination status.

XXIII. (a) In addition to the rights specified in paragraph XVIII, the patient shall be entitled to designate a spouse, family member, or caregiver who may visit the facility while the patient is receiving care. A patient who is a minor may have a parent, guardian, or person standing in loco parentis visit the facility while the minor patient is receiving care.

(b)(1) Notwithstanding subparagraph (a), a health care facility may establish visitation policies that limit or restrict visitation when:

(A) The presence of visitors would be medically or therapeutically contraindicated in the best clinical judgment of health care professionals;

(B) The presence of visitors would interfere with the care of or rights of any patient;

(C) Visitors are engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or another visitor; or

(D) Visitors are noncompliant with written hospital policy.

(2) Upon request, the patient or patient's representative, if the patient is incapacitated, shall be provided the reason for denial or revocation of visitation rights under this paragraph.

(c) A health care facility may require visitors to wear personal protective equipment provided by the facility, or provided by the visitor and approved by the facility. A health care facility may require visitors to comply with reasonable safety protocols and rules of conduct. The health care facility may revoke visitation rights for failure to comply with this subparagraph.

(d) Nothing in this paragraph shall be construed to require a health care facility to allow a visitor to enter an operating room, isolation room, isolation unit, behavioral health setting or other typically restricted area or to remain present during the administration of emergency care in critical situations. Nothing in this paragraph shall be construed to require a health care facility to allow a visitor access beyond the rooms, units, or wards in which the patient is receiving care or beyond general common areas in the health care facility.

(e) The rights specified in this paragraph shall not be terminated, suspended, or waived by the health care facility, the department of health and human services, or any governmental entity, notwithstanding declarations of emergency declared by the governor or the legislature. No health care facility licensed pursuant to RSA 151:2 shall require a patient to waive the rights specified in this paragraph.

(f) Each health care facility licensed pursuant to RSA 151:2 shall post on its website:

(1) Informational materials explaining the rights specified in this paragraph;

(2) The patients' bill of rights which applies to the facility on its website; and

(3) Hospital visitation policy detailing the rights and responsibilities specified in this paragraph, and the limitations placed upon those rights by written hospital policy on its website.

(g) Unless expressly required by federal law or regulation, the department or any other state agency shall not take any action arising out of this paragraph against a health care facility for:

(1) Giving a visitor individual access to a property or location controlled by the health care facility;

(2) Failing to protect or otherwise ensure the safety or comfort of a visitor given access to a property or location controlled by the health care facility;

(3) The acts or omissions of any visitor who is given access to a property or location controlled by the health care facility.

Summary Notice of Continuation Coverage Rights

This notice explains the options available to you for continuing or extending your Group coverage after the coverage would otherwise end.

Continuation of Coverage Under New Hampshire Law

New Hampshire law allows you to continue coverage when group coverage would otherwise end.

Continuation for Divorce or Legal Separation

If you and your spouse are divorced or legally separated while you are a member of a Group Health Plan, your former spouse is eligible to remain on your policy, as an active dependent until the earliest of the following events occurs:

- Remarriage of the Subscriber;
- Remarriage of the former spouse;
- Death of the Subscriber;
- The 3-year anniversary of the final decree of divorce or legal separation; or
- Such earlier time as provided by the final divorce decree or legal separation

Note: If the covered divorced or legally separated spouse is 55 years old or older, the former spouse may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after the date of the divorce or legal separation, *whichever occurs first.*

When one of the above events occurs, your Group Benefits Administrator must notify Anthem of your former spouse's ineligibility. Your former spouse may be eligible under the State of New Hampshire Continuation provisions described below in "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End."

If your Group replaces this coverage with another insurance carrier, your former spouse may be eligible to continue as your active dependent under the replacement policy. Please consult with the replacement carrier for complete information.

New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End

This subsection applies if you experience a Continuation Event.

- You are not an eligible employee or dependent if you were not covered under the group plan at the time of the Continuation Event.
- You are not an eligible employee or dependent if you are eligible for other group coverage or you are enrolled in Medicare when a Continuation Event occurs. If you are entitled to Medicare but not enrolled for Medicare benefits at the time of a Continuation Event, you should contact your local Social Security Office immediately for assistance because *continuation ends on the first day that you become eligible for Medicare.* For the purposes of this article, "eligible for Medicare" means that you are entitled to enroll in Medicare:

    - On a date outside the Medicare open enrollment period without application of the Medicare penalty for late enrollment, or
    - On a date during an open enrollment period, *whichever date occurs first.*

Continuation Events. Eligible employees and their eligible dependents can elect to continue group coverage under NH law when one of the following events occurs:

- Your employment is terminated for any reason (except gross misconduct),
- Your hours of employment are reduced so that you no longer qualify to participate in your employer health care plan, or
- Coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, or
- The eligible employee dies.

Eligible dependents can elect to continue group coverage when one of the following events occurs:

- A dependent child no longer meets Anthem's definition of a dependent child or incapacitated child,
- You (the ex-employee) and your dependents are on an 18-month continuation period and your continuation ends because you enroll in Medicare or you become eligible for Medicare following a Continuation Event.

Continuation Periods. You and your covered dependents may continue coverage for up to 18 months if:

- Your employment is terminated for any reason (except gross misconduct), or

- Your hours of employment are reduced so that you no longer qualify to participate in your group's health care plan.

You may continue coverage for up to 29 months if you are disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of a continuation period. (Medicare begins coverage for the disabled at 29 months.) For ease of administration, you should contact your Group and Anthem as soon as possible after you are notified of your disability status by the Social Security Administration.

Your covered surviving spouse may continue coverage for up to 36 months if coverage would otherwise end because of your death. If your surviving spouse is 55 years old or older, he or she may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after your death, *whichever occurs first.*

Your covered spouse may continue coverage for up to 36 months if coverage would otherwise end because your spouse is on an 18-month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

Your covered dependent may continue coverage for up to 36 months if coverage would otherwise end because:

- The child no longer meets Anthem's definition of a covered dependent child, or
- Because of your death, or
- The child is on an 18-month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare,
- Substantial loss of coverage by retirees and dependents within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.

Note: If any of the above events occur during an 18-month continuation period, the time spent on the 18-month period counts toward a total of 36 months of continued coverage for your child.

Notifications. Within 30 days of receiving notice from your Group's Benefit Administrator that you and/or your covered dependent(s) became ineligible for coverage under your group health benefit plan, you and/or your covered dependent(s) will receive a letter from Anthem notifying you and/or your covered dependent(s) of your right to elect to continue coverage.

Anthem's letter will contain information about your right to continue coverage, the amount of premium required to continue coverage and the procedure for electing continuation coverage. You will have 45 days from the date of Anthem's letter to make your election by:

- Notifying Anthem of your election in writing, and
- Sending a copy of your election notice to your Group.

Continuation Premium. The premium for continued coverage will not be more than 102 percent of the premium charged for employees with similar coverage. The initial premium payment must be paid to your employer at the same time as you submit your initial election of coverage. You must pay subsequent premiums and the administrative fee to your employer by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Continuation Ends. Continuation of group coverage ends on the earlier of one of the following events:

- You become eligible for other group coverage (if you enroll in another group health care plan which contains preexisting condition or waiting period limitations, you may continue coverage only until such limitations cease),
- You enroll in Medicare or on the date that you first become eligible for Medicare following a Continuation Event,
- You do not pay the required premium and administrative fee on time, or your employer (or the insurer) terminates all health benefits for all employees.
- The legal time period of your Continuation Event has expired.

Termination of the Entire Group Health Plan (39 Week Extension)

If an employer sponsored group health care plan is terminated for all employees for any reason, members who are covered at the time of such termination may elect to continue the benefits of the plan at the same group rate (plus a two percent administrative fee) as follows:

- For up to 39 weeks; (NOTE: where an individual is already on a continuation coverage, coverage shall continue until it would have expired had the plan not been terminated or for 39 weeks, whichever occurs first),

- Until the required premium is not paid on time, or

- Until the continuing member becomes eligible for benefits under another group plan (including Medicare), *whichever event occurs first.*

Exception: If you enroll in another group health benefit plan while you are continuing coverage under this statute and the new plan contains preexisting condition or waiting period exclusions or limitations, you may continue coverage under this statute only until such limitations cease.

(If your Group canceled coverage with Anthem for all employees because the Group contracted for coverage with another carrier, you are always considered to be eligible for coverage under the new plan and you are not eligible to continue coverage.)

Anthem will send you a written notice explaining your right to continue coverage under this statute within 30 days of the date your group coverage terminated. Our notice will include information about the conditions of coverage and the premiums that you must pay in order to continue coverage. The election period is a period of 31 days from the date of Anthem's notice. To elect the 39-week extension, you must do both of the following with the election period.

- Notify Anthem in writing that you elect to continue coverage under this statute, and
- Provide the first monthly premium (plus a two percent administrative fee).

Note: Our written notice will be presented to you or mailed to you. If mailed, we will use the most current address on file at our office. Provided that you notify us in writing within this additional period and provided that you submit the required payment with your notification, the effective date of your continuation under this law is the group's cancellation date. (You are responsible for making payments as billed by Anthem for your extension of group coverage under this law. You are not responsible for paying Anthem for any premiums that were the Group's responsibility prior to the Group's cancellation date.)

After we receive your written notice of election (and your premium payment plus a two percent administration fee), Anthem will bill you for subsequent payments.

You must pay the required premium and administrative fee to Anthem by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. Anthem will notify you within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Strike, Lockout or Other Labor Dispute

If your Group pays part or all of the premiums required to maintain coverage under this Booklet and your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, you the employee may maintain coverage under this Booklet for up to 6 months from the date your compensation is suspended. You must make premium payments on time directly to your Group during the 6-month period. Your Group must remit your payments to Anthem by the due date, as shown on Anthem's invoice issued to your Group.
During the 6-month period, your Group coverage cannot be altered or changed except for modifications that can occur upon expiration and renewal of your Group plan and the decreases or increases of the premium rate upon renewal.

Under New Hampshire law, your Group is required to notify you in writing immediately upon suspension or termination of your compensation as the result of a strike, lockout or other labor dispute. Notice must be sent by mail to the address last on record with your Group.

Eligibility for coverage under this subsection ends when the earliest of the following events occurs:

- You become a full-time employee with another employer, or

- Your premiums are not remitted when due. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period, or

- 6 months after your compensation is suspended or terminated as the result of a strike, lockout or other labor dispute.

After the 6-month period ends, you, the employee may continue coverage under this Booklet for an additional 12 months as if you originally had elected the rights provided under "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End" (above) and subject to the same conditions stated in "New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End."

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.
Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

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

a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.

b) 14 days after completing military service for leaves of 31 to 180 days,

c) 90 days after completing military service for leaves of more than 180 days; or

2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

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

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

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

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

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before as if you had been continually covered under the Plan from your original Effective Date.

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

Individual Insurance Offered By Anthem

When a continuation of Group coverage ends, you shall have the right to convert to an individual policy offered by Anthem.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave of absence under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being at work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must give evidence satisfactory to Anthem of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

Extension of Benefits Due To Total Disability

New Hampshire regulations provide extension rights for Members with continuous Total Disabilities, even if a Member does not elect to continue coverage as otherwise described in this section.

You are entitled to an extension of the benefits described in this Booklet when:

- Your group coverage with Anthem ends, and
- You have a continuous Total Disability on the termination date.

If you are entitled to benefits for a continuous Total Disability existing on the cancellation date, benefits for that disability will be allowed for up to 12 months beyond the Group's date of cancellation.

Your eligibility for an extension of benefits for a continuous Total Disability ends when:

- The 12-month continuous Total Disability period ends, or
- Your continuous Total Disability ends, or
- You reach the limit of benefits available to you under your Booklet, *whichever event occurs first.*

A Member has a continuous Total Disability if:

- The Member is totally disabled from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and
- The Member is not engaged in any employment or occupation for wage or profit.

You (or someone acting for you) must notify Anthem that you qualify for an extension of benefits due to Total Disability. To do so, please call Member Services for assistance.

Total Disability extensions are not available for services connected to dental expenses.

Health Insurance Marketplace

There may be other coverage options for you and your family through the Health Insurance Marketplace (www.HealthCare.gov). In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Anthem BlueCross BlueShield

SUMMARY OF THE 1996 NEW HAMPSHIRE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT (RSA 408-B) AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the covered claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

IMPORTANT DISCLAIMER

The New Hampshire Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Hampshire. Other conditions may preclude coverage.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
10 Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734

New Hampshire Department of Insurance
21 South Fruit Street, Suite 14
Concord, NH 03301
(603) 271-2261

SUMMARY:

The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law and it does not in any way change one's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE:

Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under the current, amended Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

EXCLUSIONS FROM COVERAGE:

Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state; or
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or any entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health , or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with an insurance policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;
- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery; or
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law.
- a portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date of the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of subchapter XVIII, chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C and D, or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE:

The Act also limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurance company would owe under a policy or contract.

With respect to any one life, the Association will pay a maximum of $300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverages, except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual. For life insurance benefits the Association will not pay more than $300,000 in life insurance death benefits and will not pay more than $100,000 in net cash surrender or withdrawal values. For health insurance benefits the Association will not pay more than $100,000 in health insurance benefits not defined as disability insurance or basic hospital, medical and surgical insurance or long-term care insurance, $300,000 in disability coverage, $300,000 in long-term care benefits, and $500,000 for basic hospital medical and surgical insurance or major medical insurance. For annuity benefits the Association will not pay more than $250,000 in present value of annuity benefits, including net cash surrender or withdrawal values.

The limit of coverage to one owner of multiple non-group policies of life insurance is $5,000,000.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code, the Association will pay a maximum of $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

ADDITIONAL INFORMATION:

Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

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August 2015

Discretionary Clause Endorsement

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Under ERISA, Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield (Anthem) is hereby designated by the plan sponsor as a claim fiduciary with discretionary authority to determine eligibility for benefits and to interpret and construe the terms and provisions of the policy. As claim fiduciary, Anthem has a duty to administer claims solely in the interest of the participants and beneficiaries of the employee benefit plan and in accordance with the documents and instruments governing the plan. This assignment of discretionary authority does not prohibit a participant or beneficiary from seeking judicial review of Anthem's benefit eligibility determination after exhausting administrative remedies. The assignment of discretionary authority made under this provision may affect the standard of review that a court will use in reviewing the appropriateness of Anthem's determination. In order to prevail, a plan participant or beneficiary may be required to prove that Anthem's determination was arbitrary and capricious or an abuse of discretion; and

This designation as a claim fiduciary under ERISA does not apply to determinations that health carriers make as to whether a health care service, supply or drug meets requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.