Certificate of Coverage

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

Anthem Premier DirectAccess

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

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Customer Service number.

Offered by Anthem Blue Cross and Blue Shield (the trade name for Anthem Health Plans of Virginia, Inc.)

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Post Office Box 27401
Richmond, VA 23279
855-330-1214

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. An independent licensee of the Blue Cross and Blue Shield Association.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance 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.

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, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
Eligible Subscribers and Dependents may also enroll under two additional circumstances:

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

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

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

Statement of ERISA Rights

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S.

Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Notices Required by State Law

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this coverage for any reason please contact your agent. If no agent was involved in the sale of this insurance coverage, or if you have any additional questions you may contact Anthem Blue Cross and Blue Shield ("Anthem") at the following address:

Anthem Blue Cross and Blue Shield
Attention: Customer Service Post
Office Box 27401
Richmond, VA 23279

Written correspondence is preferable so that a record of *your* inquiry is maintained. When contacting your agent, Anthem, or the Bureau of Insurance, have your contract number ready.

Virginia Bureau of Insurance

If you have been unable to contact or obtain satisfaction from Anthem, you may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, in Richmond (804) 371-9741, from outside Richmond (800) 552-7945, or at the national toll free number (877) 310-6560.

The Office of the Managed Care Ombudsman

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your health plan, you may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Telephone: 804-371-9032 (in Richmond) or 877-310-6560 (from outside Richmond)
E-Mail: ombudsman@scc.virginia.gov

Web Page: Information regarding The Office of the Managed Care Ombudsman may be found by accessing the State Corporation Commission's web page at: http://www.scc.virginia.gov.

The Virginia Department of Health Office of Licensure and Certification

If you have any questions regarding a appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by Anthem, you may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, VA 23230
Telephone: Complaint Hotline: 800-955-1819 or Richmond Metropolitan Area: 804-367-2106
Fax: 804-367-2149

Laws governing this health plan

This health plan is entered into in, and is subject to the laws of, the Commonwealth of Virginia.

This coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

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.

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

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

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

ANTHEM BLUE CROSS AND BLUE SHIELD

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Table of Contents

Schedule of Benefits – Anthem Premier DirectAccess

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

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

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

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

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

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

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

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

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	None	**$**2,000
Per Family All other Members combined	None	$4,000

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

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.

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays	80%	70%
Member Pays	20%	30%

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

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	$3,000	$6,000
Per Family – All other Members combined	$6,000	$12,000

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.

Once the Out-of- Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above.

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

Important Notice about Your Cost Shares

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

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 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
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water) Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. **Important Note:** Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see "Getting Approval for Benefits" for details.	20% Coinsurance	
Ambulance Services (Ground) Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. **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.	20% Coinsurance	
Behavioral Health Services	See "Mental Health and Substance Use Disorder Services."	
Blood and Administration of Blood Products	Benefits are based on the setting in which Covered Services are received.	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Chiropractor Services	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies	Benefits are based on the setting in which Covered Services are received. Screenings for gestational diabetes are covered under "Preventive Care."	
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	20% Coinsurance	30% Coinsurance after Deductible
The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.		
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
- Emergency Room Facility Charge	$200 Copayment Copayment waived if admitted	
- Emergency Room Doctor Charge	20% Coinsurance	
- Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	
- Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		

Benefits	In-Network	Out-of-Network
Home Care		
Home Care Visits	$10 Copayment	30% Coinsurance after Deductible
Home Dialysis	20% Coinsurance	30% Coinsurance after Deductible
Home Infusion Therapy	20% Coinsurance	30% Coinsurance after Deductible
Specialty Prescription Drugs	20% Coinsurance	30% Coinsurance after Deductible
Other Home Care Services / Supplies	20% Coinsurance	30% Coinsurance after Deductible
Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Benefit Maximum	16 hours per Benefit Period, In- and Out-of-Network combined.	
Home Infusion Therapy	See “Home Care.”	
Hospice Care		
Home Care Respite Hospital Stays	No Copayment, Deductible, or Coinsurance	30% Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan’s Maximum Allowed Amount.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Benefits are based on the setting in which Covered Services are received.	
Precertification required		
Transportation and Lodging Limit	Covered, as approved by us.	
Donor Search Limit	Covered, as approved by us.	
Donor Health Service Limit	Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Benefits	In-Network	Out-of-Network
Infertility Services	See "Maternity and Reproductive Health Services."	
Inpatient Services		
Facility Room & Board Charge:		
Hospital / Acute Care Facility	$500 Copayment per day to a maximum of $1,500 per admission	30% Coinsurance after Deductible
Skilled Nursing Facility	$500 Copayment per day to a maximum of $1,500 per admission	30% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	100 days per stay In- and Out-of-Network combined	
Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	20% Coinsurance	30% Coinsurance after Deductible
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.		
Doctor Services for:		
General Medical Care / Evaluation and Management (E&M)	20% Coinsurance	30% Coinsurance after Deductible
Surgery	20% Coinsurance	30% Coinsurance after Deductible
Lymphedema	Benefits are based on the setting in which Covered Services are received.	
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) If you change Doctors during your pregnancy, or if a pregnancy ends prior to delivery or completion of care, the prenatal and postnatal fees will be billed separately.	$250 Copayment per pregnancy No Deductible The Office Visit Copayment will also apply to the first prenatal visit.	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Inpatient Services (Delivery)	See “Inpatient Services.”	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services		
Inpatient Facility Services	$500 Copayment per day to a maximum of $1,500 per admission	30% Coinsurance after Deductible
Residential Treatment Center Services	$500 Copayment per day to a maximum of $1,500 per admission	30% Coinsurance after Deductible
Inpatient Doctor Services	20% Coinsurance	30% Coinsurance after Deductible
Outpatient Facility Services	$250 Copayment	30% Coinsurance after Deductible
Outpatient Doctor Services	20% Coinsurance	30% Coinsurance after Deductible
Partial Hospitalization Program / Intensive Outpatient Services	$250 Copayment	30% Coinsurance after Deductible
Office Visits	$10 Copayment	30% Coinsurance after Deductible
Mental Health and Substance Use Disorder Services will be covered as required by state and federal law. Please see “Mental Health Parity and Addiction Equity Act” in the “Additional Federal Notices” section for details.		
Occupational Therapy	See “Therapy Services.”	
Office Visits		
Primary Care Physician / Provider (PCP)	$10 Copayment	30% Coinsurance after Deductible
Specialty Care Physician / Provider (SCP)	$35 Copayment	30% Coinsurance after Deductible
Retail Health Clinic Visit	$10 Copayment	30% Coinsurance after Deductible
Online Visit	$10 Copayment	30% Coinsurance after Deductible
Nutritional Counseling (non-preventive)	$10 Copayment	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Allergy Testing	$10 Copayment	30% Coinsurance after Deductible
Allergy Shots / Injections (other than allergy serum)	$10 Copayment	30% Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	0% Coinsurance	30% Coinsurance after Deductible
Diagnostic Lab (non-preventive)	20% Coinsurance	30% Coinsurance after Deductible
Diagnostic X-ray (non-preventive)	20% Coinsurance	30% Coinsurance after Deductible
Diagnostic Tests (non-preventive; including hearing and EKG)	20% Coinsurance	30% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	30% Coinsurance after Deductible
Office Surgery	$35 Copayment	30% Coinsurance after Deductible
Therapy Services:		
- Chiropractic Care & Spinal Manipulation	$10 Copayment	30% Coinsurance after Deductible
- Physical, Speech, & Occupational Therapy	$10 Copayment	30% Coinsurance after Deductible
- Dialysis / Hemodialysis	20% Coinsurance	30% Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	20% Coinsurance	30% Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	$35 Copayment	30% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance	30% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	

Benefits	In-Network	Out-of-Network
Outpatient Facility Services		
Facility Surgery Charge	$250 Copayment	30% Coinsurance after Deductible
Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	30% Coinsurance after Deductible
Doctor Surgery Charges	20% Coinsurance	30% Coinsurance after Deductible
Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance	30% Coinsurance after Deductible
Other Facility Charges (for procedure rooms or other ancillary services)	$250 Copayment	30% Coinsurance after Deductible
Diagnostic Lab	20% Coinsurance	30% Coinsurance after Deductible
Diagnostic X-ray	20% Coinsurance	30% Coinsurance after Deductible
Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	20% Coinsurance	30% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	30% Coinsurance after Deductible
Therapy:		
- Chiropractic Care & Spinal Manipulation	20% Coinsurance	30% Coinsurance after Deductible
- Physical, Speech, & Occupational	20% Coinsurance	30% Coinsurance after Deductible
- Radiation / Chemotherapy / Non-Preventive Infusion & Injection	20% Coinsurance	30% Coinsurance after Deductible
- Dialysis / Hemodialysis	20% Coinsurance	30% Coinsurance after Deductible
- Cardiac Rehabilitation & Pulmonary Therapy	20% Coinsurance	30% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
Prescription Drugs Administered in an Outpatient Facility	20% Coinsurance	30% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”	

Benefits	In-Network	Out-of-Network
Preventive Care	No Copayment, Deductible, or Coinsurance	30% Coinsurance after Deductible
Prosthetics	See “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies.”	
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Telemedicine	$10 Copayment	30% Coinsurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
Physical & Occupational Therapy	30 visits per Benefit Period	

Benefits	In-Network	Out-of-Network
Speech Therapy	30 visits per Benefit Period	
Chiropractic Care & Spinal Manipulation	30 visits per Benefit Period	
Cardiac Rehabilitation	Unlimited	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office Visits)		
Urgent Care Office Visit Charge	$35 Copayment	30% Coinsurance after Deductible
Allergy Testing	$35 Copayment	30% Coinsurance after Deductible
Allergy Shots / Injections (other than allergy serum)	$35 Copayment	30% Coinsurance after Deductible
Preferred Diagnostic Labs (i.e., reference labs)	0% Coinsurance	30% Coinsurance after Deductible
Other Charges (e.g., diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	30% Coinsurance after Deductible
Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	30% Coinsurance after Deductible
Office Surgery	$35 Copayment	30% Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance	30% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		

Benefits	In-Network	Out-of-Network
Vision Services For Members Through Age 18 **Note:** To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam Limited to one exam per Benefit Period	$0 Copayment	Covered up to $30
Standard Plastic Lenses Limited to one set of lenses per Benefit Period In-Network or one set of lenses every other year Out-of-Network. Available only if the contact lenses benefit is not used.		
Single Vision	$0 Copayment	Covered up to $25
Bifocal	$0 Copayment	Covered up to $40
Trifocal	$0 Copayment	Covered up to $55
Progressive	$0 Copayment	Covered up to $40
Note: In-Network, lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photocromic lenses are also covered at no extra cost In-Network.		
Frames Limited to one set of frames from the Anthem Formulary per Benefit Period In-Network or one set of frames every other year Out-of-Network.	$0 Copayment	Covered up to $45
Contact Lenses Limited to one set of contact lenses from the Anthem formulary per Benefit Period In-Network or one set of contact lenses every other year Out-of-Network. Available only if the frames benefit is not used.		
Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	Covered up to $60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Covered up to $210

Benefits	In-Network	Out-of-Network
Vision Services For Members Age 19 and Older **Note:** To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
Routine Eye Exam Limited to one exam per Benefit Period	$20 Copayment	Covered up to $30
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.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$5 Copayment	30% Coinsurance
Tier 2 Prescription Drugs	$30 Copayment	30% Coinsurance
Tier 3 Prescription Drugs	$60 Copayment or 25% Coinsurance (whichever is greater) to a maximum of $250 per Prescription Drug	30% Coinsurance

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$13 Copayment	30% Coinsurance
Tier 2 Prescription Drugs	$75 Copayment	30% Coinsurance
Tier 3 Prescription Drugs	$150 Copayment or 25% Coinsurance (whichever is greater) to a maximum of $625 per Prescription Drug	30% Coinsurance

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail 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 a Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. We reserve the right, in our sole discretion, to remove certain higher cost Generic Drugs from this policy.

How Your Plan Works

Introduction

Your Plan is a 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.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

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

To see a Doctor, call their office:

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

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

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.

For services from In-Network Providers:

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

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

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

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);

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

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

5. You may have to file claims; and

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

How to Find a Provider in the Network

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

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Continuity of Care

The PPO network is subject to change as health care providers are added to the network, move, retire, or change their status. When providers decide to leave the network, they become non-participating providers, and services, unless properly authorized, will not be covered at the In-Network level.

There are four instances when members may continue seeing providers who have left the network:

1. Terminated providers may continue to treat a Member for 90 days, if the Member is under an active course of treatment with the provider, the Member requests such continuing care, and the provider has not been terminated for cause.
2. A Member in the second or third trimester of pregnancy may continue seeing her obstetrician gynecologist through postpartum care for that delivery.
3. Members with life expectancy of six months or less may continue seeing their treating physician.
4. You have chosen to receive services on an out-of-plan basis.

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 us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product 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 our products, and you change from one product 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 products or carriers in addition to ours, and you change products or carriers to enroll in this product 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:

- Change from one of our individual policies to a group plan;
- Change employers; or
- Are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need health care, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States – BlueCard® Worldwide
Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call us to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to us.

Claim Forms
You can get international claim forms from us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

Identification Card

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

Getting Approval for Benefits

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed.

Prior Authorization: Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **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. For Emergency admissions, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination –** An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental / Investigational as that term is defined in this Booklet.

- **Post Service Clinical Claims Review –** A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, 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.

Who is responsible for Precertification	
Services given by an In-Network Provider	**Services given by a BlueCard/Out-of-Network/Non-Participating Provider**
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, 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.

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical polices and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Group Contract take precedence over these guidelines.

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

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our 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 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 by checking your on-line Provider Directory or contacting the Customer Service number on the back of your ID card.

Request Categories

- **Emergent –** A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective –** A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review –** A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective –** A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent 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
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

We will give notice of our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including e-mail and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. 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 benefit 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.

Individual Case Management

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

Our Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.

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

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

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

What's Covered

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

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

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

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- 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.

- 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. When using an air ambulance, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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.

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 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.**

Behavioral Health Services

See "Mental Health and Substance Use Disorder Services" later in this section.

Blood and Administration of Blood Products

Your Plan includes coverage for blood and the administration of blood products for the treatment of hemophilia and congenital bleeding disorders.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services 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 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.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

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

Hospitalization for Anesthesia and Dental Procedures

Your plan includes coverage general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or Outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.

Diabetes Equipment, Education, and Supplies

Your Plan covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes, and hypodermic needles and syringes when purchased from a pharmacy; and
- outpatient self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Screenings for gestational diabetes are covered under Preventive Care.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, pathology reports, and cardiology. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Sleep Testing

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography
- Single photon emission computed tomography (SPCECT) scans

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

Dialysis

See “Therapy Services” later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and

continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

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

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Orthotics

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

Prosthetics

Your Plan also includes benefits for prosthetics and components when they are Medically Necessary for activities of daily living. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments and replacement of a prosthetic device. In additional, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Covered Services may include, but are not limited to:

1) Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device);
2) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
3) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
4) Restoration prosthesis (composite facial prosthesis)
5) Wigs needed after cancer treatment.

Medical and Surgical Supplies

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

Medical Formulas

Your Plan covers special medical formulas which are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Devices and Supplies for Sleep Treatment

Your Plan includes coverage for devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to Medical Necessity reviews by us.

Early Intervention Services

Your Plan covers early intervention services for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be medically necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention benefit.

Emergency Care Services

Emergency Services

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

Emergency (Emergency Medical Condition)

"Emergency,"" or "Emergency Medical Condition" means a medical 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 in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

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

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

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

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

1. The amount negotiated with In-Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Out-of-Network services but substituting the In-Network cost-sharing for the Out-of-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

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

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

Home Care Services

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

Covered Services include but are not limited to:

- 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.
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment

Home Infusion Therapy

See "Therapy Services" later in this section.

Hospice Care

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities.
- 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 pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than six months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be 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.

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

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, harvest 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 our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Customer Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant

Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before we will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest 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.

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

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.

- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Lymphedema

Your Plan includes benefits for expenses incurred in connection with the treatment of lymphedema, including benefits for equipment, supplies, complex decongestive therapy, and outpatient self management training and education.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Pregnancy testing;
- Professional and Facility services for childbirth including use of the delivery room and care for normal deliveries, in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Anesthesia services to provide partial or complete loss of sensation before delivery;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services for the mother;
- Postnatal services for the baby, including hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening, PKY screening and Rh incompatibility testing; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

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

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants

Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

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

Abortion Services

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

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, convulsive therapy, detoxification, and rehabilitation.

- **Outpatient Services** including treatment in an outpatient department of a Hospital and office visits. Covered services include individual psychotherapy, group psychotherapy, psychological testing and medication management visits (visits to your physician to make sure that the mediation you are taking for a mental health or substance use disorder is working and the dosage is right for you).

- **Partial Day Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital. A partial day program must be licensed or approved by the state and must include either a day or evening treatment program, which lasts at least 6 or more continuous hours per day for mental health or substance use disorder, or an intensive outpatient program, which lasts 3 or more continuous hours per day for treatment of alcohol or drug dependence.

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center or intermediate care Facility. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, education, and recreational or social activities.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,

- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

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

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

Retail Health Clinic Care for limited basic health care services to Members 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.

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

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

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

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a medical condition associated with the screening service.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit for that particular problem or condition.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means we cover 100% of the Maximum Allowed Amount. Covered Services fall under four 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,
    b. Cervical cancer,
    c. Colorectal cancer,
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.

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

3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration (including infant hearing screening); and

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

    a. Women’s contraceptives including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization treatments, and counseling. Contraceptive coverage includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also

covered. Multi-source Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
c. Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
d. Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of Pap smear results.
e. Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
f. Screening and counseling for interpersonal and domestic violence.
g. Well woman visits.

5. Counseling services related to nutrition, and to smoking and tobacco use cessation.

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites, http:// www.healthcare.gov/center regulations/prevention.html, http://www.ahrq.gov clinic/uspstfix.htm, and http://www.cdc.gov/vaccines/acip index.html.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services as required by state law:

- Routine screening mammograms
- Routine prostate specific antigen testing and digital rectal exams

Prosthetics

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

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

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

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, medical devices, 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.

Habilitative Services

Benefits also include habilitative services 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, medical devices, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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. The following items and services will be provided to you as an inpatient in a skilled nursing bed of a skilled nursing facility:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies.

Your Plan will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your inpatient benefits would cover the skilled nursing facility's charges for a semi private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your copayment and coinsurance (if any).

Smoking Cessation

Please see "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" later in this Booklet.

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;
- Surgeries and procedures to correct congenital abnormalities that cause functional impairment and congenital abnormalities in newborn children;
- 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.

Important Note About Hysterectomy Admissions: Hospital admissions for a covered laproscopy assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

Bariatric Surgery

If your Plan covers bariatric surgery, coverage will be outlined in a separate rider endorsement found at the end of this booklet.

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or 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 on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Important Note About Mastectomy Admissions: Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours.

Telemedicine

You Plan covers interactive Telemedicine Services, which is the use of audio, video or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include an audio-only telephone conversation, electronic mail message, or facsimile transmission.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, 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. Coverage for these Covered Services is described more completely under Rehabilitation Services and Habilitative Services earlier in this section. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Early Intervention Services

See "Early Intervention Services" earlier in this section.

Other Therapy Services

Benefits are also available for:

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

Transplant Services

See "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

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

Benefits for urgent care include:

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

Vision Services For Members To Age 19

The vision benefits described in this section only apply to Members to age 19.

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

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

The Plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;

- Non-Elective Contact Lenses – Only for the following medical 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: Benefits are not available for non-elective contact lenses if the Member has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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

Vision Services for Members Age 19 and Older

The vision benefits described in this section only apply to Members age 19 or older.

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.

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 include the cost of prescribed glasses or contact lenses when required as a result of surgery, or for the treatment of accidental injury. Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
    - contact lenses are used for the treatment of infantile glaucoma;
    - corneal or scleral lenses are prescribed in connection with keratoconus;
    - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
    - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable 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.

Note: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

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 Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details we need to decide if prior authorization should be given. We will give the results of our decision to both you and your Provider.

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

For a list of Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Plan. Your Provider may check with us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before we will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, prior authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic Drug substitutes list, which we review and update from time to time. For questions or issues about therapeutic Drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

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

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

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, 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

As described in the "Prescription Drugs Administered by a Medical Provider" section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include prior authorization, step therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details we need to decide benefits.

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.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration)
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- Smoking cessation products and over the counter nicotine replacement products (limited to nicotine patches and gum) when obtained with a Prescription. These products will be covered under the "Preventive Care" benefit.

We cannot deny prescription drugs (or inpatient or IV therapy drugs) used in the treatment of cancer pain on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

Specialty Pharmacy

If you need a Specialty Drug, you or your Doctor should order it from the PBM's Specialty Pharmacy. We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

The PBM's Specialty Pharmacy has dedicated patient care coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs.

When you use the PBM's Specialty Pharmacy a patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to you or your Doctor's office. 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 Customer Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy

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

Out-of-Network Pharmacy

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

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

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

Services of non-participating pharmacies

Notwithstanding any provision in this Booklet to the contrary, you have coverage for outpatient prescription drug services provided to you by an Out-of-Network pharmacy that has previously notified the PBM of its agreement to accept reimbursement for its services at rates applicable to In-Network pharmacies including any applicable copayment, coinsurance and/or deductible (if any) amounts as payment in full to the same extent as coverage for outpatient prescription drug services provided to you by an In-Network provider. Note, however, that this paragraph shall not apply to any pharmacy which does not execute a participating pharmacy agreement with the PBM or its designee within thirty days of being requested to do so in writing by the PBM, unless and until the pharmacy executes and delivers the agreement.

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs or Specialty drugs (including therapeutic biological products).
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier contains preferred Drugs that may be Generic, single source, or multi-source Brand Drugs or Specialty drugs (including therapeutic biological products).
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier contains non preferred and high cost Drugs. This includes Drugs considered Generic, single source brands, and multi-source brands or Specialty drugs (including therapeutic biological products).

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

Prescription Drug List

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

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

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

There are two exceptions to the formulary requirement:

- You may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if we determine, after consultation with the prescribing physician, that the formulary drugs are inappropriate for your condition
- You may obtain coverage without additional cost sharing beyond that which is required of formulary prescription drugs for a non-formulary drug if:
    - You have been taking or using the non-formulary prescription drug for at least six months prior to its exclusion from the formulary; and
    - The prescribing physician determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

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

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Customer Service at the number on the back of your Identification Card.

Half-Tablet Program

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

Special Programs

From time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

What's Not Covered

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

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

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

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

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

   a) Acupuncture,
   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) Bioenergial 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) **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.

5) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

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

7) **Complications of Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

8) **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 psychiatric, psychological, or 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:

   a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.

   b) Surgery or procedures to correct congenital abnormalities that cause functional impairment.

   c) Surgery or procedures on newborn children to correct congenital abnormalities

   The Plan will not consider the patient's mental state in deciding if surgery is cosmetic.

9) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

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

11) **Dental Treatment** Dental treatment, except as listed below.

   Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

   - Removing, restoring, or replacing teeth;
   - Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
   - Services to help dental clinical outcomes.

   Dental treatment for injuries that are a result of biting or chewing is also excluded.

   This Exclusion does not apply to services that we must cover by law.

12) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.

13) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This 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 we conclude it is Experimental / Investigational.

   Please read the Experimental or Investigational definition in the "Definitions" section at the end of this Booklet for the criteria used in deciding whether a service is experimental/investigative.

14) **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 or accidental injury.

15) **Eye Exercises** Orthoptics and vision therapy.

16) **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.

17) **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.

18) **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:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

    This Exclusion does not apply to the treatment of corns, calluses, and care of toenails for patients with diabetes or vascular disease.

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

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

21) **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 Workers' Compensation benefits are not available to you, 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.

22) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

23) **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.

24) **Home Care**

    a) 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.

    b) Food, housing, homemaker services and home delivered meals.

25) **Infertility Treatment** Treatment related to infertility.

26) **Maintenance Therapy** 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.

    The exception to this Exclusion is habilitative services described earlier in this Booklet.

27) **Medical Equipment and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

28) **Medicare** For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by

federal law, as described in the section titled "Medicare" in “General Provisions.” If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

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

30) **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.

31) **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.

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

33) **Personal Care and Convenience**

    a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

    b) 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),

    c) Home workout or therapy equipment, including treadmills and home gyms,

    d) Pools, whirlpools, spas, or hydrotherapy equipment.

    e) Hypo-allergenic pillows, mattresses, or waterbeds,

    f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

34) **Private Duty Nursing** Private Duty Nursing Services, unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nursing in the inpatient setting.

35) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.

36) **Providers** Services you get from a non-covered Provider, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

37) **Residential Treatment Centers** This exclusion does not apply when such setting qualifies as a substance use disorder treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care.

38) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.

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

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

41) **Sterilization** Services to reverse elective sterilization

42) **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).

43) **Telemedicine** Non-interactive telemedicine services, such as audio-only telephone conversations;, electronic mail message or fax transmissions.

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

45) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

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

47) **Vision Services**

a) Vision services for Members age 19 or older, unless listed as covered in this Booklet.

b) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.

c) Safety glasses and accompanying frames.

d) For two pairs of glasses in lieu of bifocals.

e) Plano lenses (lenses that have no refractive power)

f) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period.

g) Vision services not listed as covered in this Booklet.

h) Cosmetic lenses or options.

i) Blended lenses.

j) Oversize lenses.

k) Sunglasses and accompanying frames.

l) For services or supplies combined with any other offer, coupon or in-store advertisement.

m) For Members to age 19, no benefits are available for frames not on the Anthem formulary.

n) Certain frames in which the manufacturer imposes a no discount policy.

48) **Vision Services** Vision services not described as Covered Services in this Booklet.

49) **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.

50) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Compound Drugs** Compound Drugs unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.
3. **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.

4. **Delivery Charges** Charges for delivery of Prescription Drugs.
5. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "**Prescription Drugs Administered by a Medical Provider**" section or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
6. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. There are two exceptions to the formulary requirement. Please see the "Prescription Drug List" sub-section in "**Prescription Drugs Administered by a Medical Provider**" section for information about the exception process.
7. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

   This Exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
8. **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
9. **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.
10. **Fluoride Treatments** Topical and oral fluoride treatments.
11. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
12. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
13. **Items Covered as Medical Supplies** Oral immunizations and biologicals, even if they are federal legend Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services unless we must cover them under federal law.
14. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
15. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
16. **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.
17. **Non-approved Drugs** Drugs not approved by the FDA.
18. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
19. **Onychomycosis Drugs** Drugs for Onchomycosis (toenail fungus) except when we allow it to treat Members who are immune-compromised or diabetic.
20. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend 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 under federal law with a Prescription.

21. **Sex Change Drugs** Drugs for sex change surgery.
22. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
23. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self injectable Drugs and medicine.
24. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Claims Payment

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

Maximum Allowed Amount

General

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

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

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

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

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

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

"Per diem amount" means an all inclusive fixed payment amount for each day of admission in an inpatient facility.

Provider Network Status

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

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

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

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

1. An amount based on our non-participating Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: the statewide average reimbursement amounts that Anthem previously has paid for similar claims in the State of Virginia, reimbursement amounts accepted by like/similar Providers contracted with Anthem, reimbursement rates accepted by Providers under the last network contract in effect with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level and/or method of reimbursement used by CMS, Anthem will update such information, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or

4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

A per diem amount may be used in calculating the Maximum Allowed Amount for Inpatient facility services. When calculating these amounts, the charges for non Covered Services are subtracted from the per diem amount.

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

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

Customer Service 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 Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

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

Member Cost Share

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

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

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The Maximum Allowed Amount for Inpatient facility services may be based on a per diem amount. When calculating these amounts, the charges for non Covered Services are subtracted from the per diem amount.

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

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

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

- *The Out-of-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total out of pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.*

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

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

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and we will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

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

Notice of Claim & Proof of Loss

Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the health plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

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

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Customer Service and ask for a claims form to be sent to you. Claim forms will be furnished to you if needed within 15 days after this written notice. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payor), you will be responsible for any charge for services.

Payment of Benefits

We will make benefit payments directly to Network Providers for Covered Services. If you use an Out-of-Network Provider, however, we may make benefit payments to you. 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 may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any benefit payments made by us will discharge our obligation for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted. You may not assign your right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a

waiver of, or otherwise restrict, our right to direct future payments to you or any other individual or facility. Notwithstanding any provision in this EOC to the contrary, however, Anthem will reimburse directly any ambulance service provider to whom the member has executed an assignment of benefits.

Once a claim has been processed, if your portion of the bill is anything other than zero or equal to a flat copayment amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to you to explain your responsibility. In the event that your portion of the bill is zero or equal to a flat copayment amount, the paper copy will not be mailed, but will available to you online at www.anthem.com. If you do not have access to the Internet, you may contact Customer Service to arrange for a printed copy.

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem's Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem's payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem 's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem 's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When covered healthcare services are provided outside of our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within our Service Area, or a special negotiated payment, as permitted under Inter Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowed Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

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

Coordination of benefits (COB)

Special coordination of benefits (COB) rules apply when you or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision. This provision applies if the total payment under this agreement absent this provision and under any other contract is greater than the value of covered services.

Primary coverage and secondary coverage

When a member is also enrolled in another group health plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules.

When this health plan provides secondary coverage, we first calculate the amount that would have been payable had this health plan been primary. In no event will this health plan's payment as secondary coverage exceed that amount. This health plan coordinates benefits so that the combination of the primary plan's payment and this health plan's payment does not exceed our maximum allowed amount. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

Definition of "Other Contract"

Other Contract means any arrangement providing health care benefits or services through:

- group or blanket insurance coverage;
- group Blue Cross Blue Shield, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one Other Contract, this provision will apply separately to each. If an Other Contract has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

Anthem will not determine the existence of any other contract, or the amount of benefits payable under any other contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under other contracts only when Anthem is given information about other contracts.

If the rules of this agreement and the other contract both provide that this agreement is primary, then this agreement is primary. When Anthem determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the other contract's payment will not exceed Anthem's Maximum Allowed Amount for covered services.

Order of Benefit Determination Rules

If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:

- secondary to the contract covering the person as a dependent; and
- primary to the contract covering the person as other than a dependent (e.g., a retired employee);
- then the benefits of the contract covering the person as a dependent are determined before those of the contract covering the person as other than a dependent.

For children who are covered under both parents' contracts, the following will apply:

- The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
- When parents are separated or divorced, the following special rules will apply:
    - If the parent with custody has not remarried, that parent's contract will be primary.
    - If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
    - The rules listed above may be changed by a court decree:
        - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
        - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.

If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.

If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his dependent) will be primary. The contract of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.

If another contract has different rules from those listed above other than the gender rule, that contract will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any other contract, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, Anthem will no longer be liable under this agreement.

The preceding paragraph does not apply to claims for outpatient prescription drugs provided by a pharmacy when Medicare Part D provides the covered person's primary prescription drug coverage. See the following section for more information.

How prescription drug benefits are coordinated when Medicare Part D is primary

If Medicare Part D provides your primary coverage for outpatient prescription drugs provided by a pharmacy, we first calculate the amount that would have been payable had this health plan been primary. We then pay a secondary benefit up to that amount, in order to reduce any amount you had to pay out of pocket under Medicare Part D. The benefit we pay is limited to the lesser of the amount you paid out-of-pocket under Medicare Part D or the amount this health plan would have paid if it had been primary.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, we're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to our network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity..
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - our company and services.
    - our network of doctors and other health care providers .
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - Your Plan
    - Any care you get
    - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care Providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care Providers.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with us.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing quality benefits and customer service to our Members. Benefits and coverage for services provided under the benefit program are governed by the Booklet and not by this Member Rights and Responsibilities statement.

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

Grievance and External Review Procedures

In order for Anthem to remain responsive to your needs, we have established both a complaint process and a grievance process. Should you have a problem or question about your health plan, a Customer Service representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about your health plan's services, quality of care, the choice of and accessibility to your health plan's providers and network adequacy. Grievances typically involve a request to reverse a previous decision made by your health plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of your health plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Written complaints may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Customer Service P.O.
Box 27401
Richmond, VA 23279

Grievance Process

Anthem is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Types of appeals include:

- internal appeals are requests to reconsider rescissions or coverage decisions of pre-service or post-service claims. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain; and
- external reviews are requests for an independent, external review of coverage decisions made by your health plan through its internal appeal process. More information about this type of appeal may be found in the **"Independent external review of adverse utilization review decisions"** paragraph of this section.

How to appeal a coverage decision

To appeal a coverage decision (including a rescission), please send a written explanation of why you feel the coverage decision was incorrect. You or your authorized representative acting on your behalf may submit the written explanation. Alternatively, this information may be provided to a Customer Service representative over the phone. This is your opportunity to provide any comments, documents, or

information that you feel your health plan should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- in the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

You may contact Customer Service with your appeal or any questions concerning your health insurance. To contact Customer Service please call the number on the back of your Identification Card. When submitting your grievance in writing, it should be sent to the following address:

For Medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross and Blue Shield
Attention: Grievance Department
P.O. Box 27401
Richmond, VA 23279

For Vision Benefits Issues:
Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

You must file your appeal within either 15 months of the date of service or 180 days of the date you were notified of the adverse benefit determination, whichever is later.

How Anthem will handle your appeal

In reviewing your appeal, we will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will promptly acknowledge receipt of your appeal, and will resolve and respond to it as follows:

- For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims and rescissions, we will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, we will respond to you and your provider as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on new or additional rationale, we will provide you, free of charge, with the rationale.

When our review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

If we deny your appeal, you will be provided with other dispute resolution options as applicable, including external review through the Bureau of Insurance.

Independent external review of adverse utilization review decisions

If we have denied your claim, you may have the right to request an independent external review of our decision by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested (including whether the service or treatment was determined to be experimental or investigative). Except when an expedited external review is warranted as described below, the external review process is available only if the denial is upheld after you file an internal appeal with us. This is called a standard external review.

You or your authorized representative may request an expedited external review with the Bureau of Insurance at the same time as exercising our expedited appeal process. An expedited external review may also be requested if our adverse decision was based upon our judgment that the services rendered were experimental or investigative and your treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

If you have not already requested an expedited external review in advance of our decision to deny your claim on appeal, you may do so after our appeal decision if:

- you have a medical condition where the time frame for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function;
- this decision concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not been discharged from a facility; or
- this decision is based on our judgment that the services rendered were experimental or investigative and your treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

To request a standard or expedited external review with the Bureau of Insurance you may contact the Corporate Appeals Department listed above, or contact the Bureau of Insurance directly at: Bureau of Insurance – External Review P.O. Box 1157 Richmond VA 23218, Telephone: 877-310-6560, E-Mail: externalreview@scc.virginia.gov.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

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

Dependents

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

- The Subscriber's spouse as recognized under the laws of the state where the Subscriber lives.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- The age limit does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of intellectual disability, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the subscriber provides proof of handicap and dependence at the time of enrollment. For the child enrolled prior to reaching the age limit, coverage may continue beyond the age limit if the subscriber provides proof of handicap and dependence within 31 days after he/she reaches the age limit. You may be asked to provide physician's certification of the dependent's condition. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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

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

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

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

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

When You Can Enroll

Initial Enrollment

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

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

Open Enrollment

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

Special Enrollment Periods

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

Special Enrollment is available for eligible individuals who:

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

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required and must be furnished by you or your prior carrier.

Medicaid and Children's Health Insurance Program Special Enrollment

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

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or

- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

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

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they may apply for coverage at any time during the year as a Late Enrollee. However, you will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 31 days to add the newborn to your Plan.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 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, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

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

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

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, or age. Providers operating within the scope of practice, license or certification cannot be discriminated against.

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination

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

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation or conversion requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.

- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services. If your coverage is rescinded we will make an equitable adjustment of Premium to your Group, taking into account benefits that may have been paid. Please see your Group concerning any refund to which you may be entitled.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

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

Removal of Members

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

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health plan.

Continuation of Coverage Under Federal Law (COBRA)

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

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

Initial Qualifying Event	Length of Availability of Coverage
For Subscribers:	
Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
For Dependents:	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
For Dependent Children:	36 months

Initial Qualifying Event	Length of Availability of Coverage
Loss of Dependent Child Status	

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

If Your Group Offers Retirement Coverage

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

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage Provider, reducing the amount you have to pay out of pocket.

When COBRA Coverage Ends

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

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

If You Have Questions

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

Switching to Individual Coverage

To prevent a lapse in coverage, contact Anthem within 31 days after issuance of the written notice described in the **Notice of continuation options** section below, but in no event beyond the 60 day period following the date coverage ends. If you meet enrollment requirements for an individual plan and apply within the time limit, there will be no lapse in coverage. Otherwise, claims may not be paid for a period of time. To make sure you know what will be covered, read the individual Anthem offer carefully. It will outline:

- enrollment rules;
- the time permitted to accept the offer;
- the waiting period, if any; and
- the benefits and rates of the individual plan.

Twelve-Month Continuation

This section pertains to you only if your employer's group health plan is not subject to the requirements of the COBRA law. Also, even if the employer's group health plan is not subject to the requirements of COBRA, the group policyholder must elect to administer the continuation option set forth in this section for all enrolled employees and their dependents as of its most recent policy renewal or effective date for this section to be effective.

If you or a dependent loses eligibility for your group's coverage, you may be able to continue group coverage for a period of 12 months beginning immediately following the date of the termination of the person's eligibility, without evidence of insurability. The following rules apply:

- the person must have been enrolled under the plan for at least 3 months;
- the person must not be eligible for Medicare or Medicaid benefits prior to the loss of eligibility for group coverage;
- the person must apply for coverage with the group policyholder and pay the first month's premium within 31 days after issuance of the written notice described in the **Notice of continuation options** section below, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
- premium for such extended coverage is timely paid to the group policyholder on a monthly basis during the twelve-month period; and
- the premium for continuing the group coverage shall be at the insurer's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate.

Notice of continuation options

The group policyholder shall provide each employee or other person losing coverage under such policy written notice of the opportunity to purchase individual coverage, or if elected by the group policyholder with respect to a health plan not subject to COBRA, written notice of the availability of the twelve month continuation option. Such notice shall be provided within 14 days of the policyholder's knowledge of your loss of eligibility under the policy. If the group policyholder does not provide the required notice, please contact Customer Service directly within 60 days from the date you lose eligibility for coverage to discuss your continuation options.

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 waiting / probationary periods will apply only to the extent that they applied before.

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

Family and Medical Leave Act of 1993

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

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

Benefits After Termination Of Coverage

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Group's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Group termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

General Provisions

Assignment

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

Clerical Error

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

Confidentiality and Release of Information

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

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

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

Conformity with Law

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

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Health Plans of Virginia, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Virginia. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Group for any of Anthem‘s obligations to the Group created under the Contract. This paragraph shall not create any additional

obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

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

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. All statements made by the policyholder or by the persons insured shall be deemed representations and not warranties. No written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person or to his beneficiary or personal representative. A copy of any application of the policyholder shall be attached to the policy when issued.

Form or Content of Booklet

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

Government Programs

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

Grace Periods

If premium payment is not made in full by your Group on or prior to the premium due date, a 31-day grace period shall be granted to your Group for payment. The grace period shall begin on the premium due date and continue for 31 days. During the grace period, coverage shall remain in effect. If payment is not made by your Group within the grace period, Anthem may cancel coverage after the 31-day grace period or 15 days after Anthem has provided your Group with a written or printed notice of termination, including a specific date, whichever is later. Your Group will be liable to Anthem for any premium owed for the time the coverage is in force during a grace period.

Group Contribution

Your Group shall offer Anthem to all Members of the Group on terms no less favorable with respect to the total group contribution than those applicable to such other health benefits coverage as may be available through the Group. Except as hereinafter provided, your group contributions set forth in the premium schedule on the Group Application, and in any subsequent premium revisions, shall not be changed during the term of this Agreement unless such change is agreed to in writing by Anthem. If, however, your Group's contribution to such other coverage as may be available through your Group is increased during the term of this Agreement, your Group agrees to increase its contribution for Anthem coverage, effective the first premium due date following such increase.

Incontestability

The validity of this Group Contract shall not be contested, except for non-payment of premiums, after it has been in force for 2 years from the date indicated on the cover page of the Group Contract. No statement made by an enrollee relating to: (i) his insurability; or (ii) the insurability of his dependents, shall be used in contesting the validity of the coverage of the person about whom the statement was made after coverage has been in force for a period of 2 years. Any such statement must be submitted in writing and signed by the enrollee.

Individual Certificates

Anthem will at its option issue either (1) to the policyholder for delivery to each enrollee, or (2) to each enrollee a certificate setting forth:
1. The enrollee's coverage, including any limitations, reductions and exclusions applicable to the coverage;
2. To whom the insurance benefits are payable;
3. Any family member's or dependent's coverage; and
4. The conversion rights afforded under this health plan.

Legal Action

No legal action may be brought against Anthem within the 60-day period after proof of loss notice is filed or more than three years after the end of the 90-day period that proof of loss was required to be filed. This limit applies to matters relating to this health plan, to our performance under this health plan, or to any statement made by an employee, officer, or director of Anthem concerning this health plan or the benefits available to a covered person.

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 Payor 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 payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, 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. For the purposes of the calculation

of benefits, if you have not enrolled in Medicare Part B, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

Misstatement of Age

If the premiums charged for coverage vary by the age of the covered person, a fair adjustment of premiums shall be made if the age of the covered person has been misstated. Anthem will only be liable to adjust premiums retroactive to the last annual renewal date of this policy.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

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

Physical Examinations and Autopsy

Anthem shall have the right:

- to examine the covered person for whom a claim is made when and as often as it may reasonably require during the pendency of a claim under the policy; and
- to make an autopsy where it is not prohibited by law.

Policies and Procedures

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

Under the terms of the Group Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time. We will give thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Relationship of Parties (Group-Member-Anthem)

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

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

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

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

Right of Recovery

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. In the event we recover a payment made in error from the Provider, except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs

and expenses and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not give you notice of overpayments made by us or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Identification Card

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

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

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

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed and could be discontinued at any time. If your Group has selected one of these options, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors when administered according to state or federal law. However, if it is unreasonably difficult due to a medical condition for you to achieve the standards for a reward under such a program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, we will work with you to develop another way to qualify for the reward. (If you receive gift cards and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

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

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf, to us if we have made payment for the services received. 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 have questions on any of these definitions, please call Customer Service at the number on the back of your Identification Card.

Accidental Injury

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

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

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

Authorized Service(s)

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

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The 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.

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.

Coinsurance

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

Copayment

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

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 an Inpatient stay is the date of you enter the Facility except as described in "Benefits After Termination Of Coverage".

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

Covered Transplant Procedure

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

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; and (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.

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.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

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

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Means any service or supply that is judged to be experimental or investigative at Anthem's sole discretion. Nothing in this exclusion shall prevent a member from appealing Anthem's decision that a service is experimental / investigative. Services which do not meet each of the following criteria will be excluded from coverage as experimental/investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
    - This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
        - the following three standard reference compendia defined below:
            - American Hospital Formulary Service - Drug Information
            - National Comprehensive Cancer Network's Drugs & Biologics Compendium
            - Elsevier Gold Standard's Clinical Pharmacology
        - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for

scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

- In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by us.

Group

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

Group Contract (or Contract)

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

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

Home Health Care Agency

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

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

Hospice

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

Hospital

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

1. room, board, and nursing care;
2. a staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. all the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. custodial care
6. educational care
7. subacute care
8. treatment of alcohol abuse
9. treatment of drug abuse

Identification Card

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

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

Inpatient

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

Late Enrollees

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

Maximum Allowed Amount

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

Medical Necessity (Medically Necessary)

To be considered medically necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;

- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Member

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

Open Enrollment

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

Out-of-Network Provider

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

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

Out-of-Pocket Limit

The most you pay during a Benefit Period for Covered Services before your Plan begins benefits. 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. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. Please see the "Schedule of Benefits" for details.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

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

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

Plan

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

Precertification

Please see the section “Getting Approval for Benefits” for details.

Predetermination

Please see the section “Getting Approval for Benefits” for details.

Premium

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

Prescription Drug (Drug)

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

1) Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2) Insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

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

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Covered Providers are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Referral

Please see the “How Your Plan Works” section for details.

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 Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by state regulatory agencies.

Skilled Nursing Facility

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

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

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

Special Enrollment

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

Specialist (Specialty Care Physician \ Provider or SCP)

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

Specialty Drugs

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

Subscriber

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

Telemedicine Services

Means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services. Telemedicine services do not include audio-only telephone conversation, electronic mail message or facsimile transmission.

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.