

Certificate of Coverage

(Referred to as "Booklet" in the following pages)

Anthem Preferred DirectAccess – gvea



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 Customer Service at the number on the back of your Identification Card.

**Anthem Health Plans of Kentucky, Inc.
9901 Linn Station Road
Louisville, KY 40223**

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 abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse 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.

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!

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.

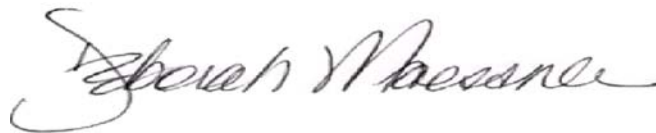


Table of Contents

| | |
|---|-----------|
| Federal Patient Protection and Affordable Care Act Notices | 1 |
| Choice of Primary Care Physician..... | 1 |
| Access to Obstetrical and Gynecological (ObGyn) Care | 1 |
| Additional Federal Notices..... | 2 |
| Statement of Rights under the Newborns' and Mother's Health Protection Act..... | 2 |
| Statement of Rights under the Women's Cancer Rights Act of 1998 | 2 |
| Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")..... | 2 |
| Mental Health Parity and Addiction Equity Act | 2 |
| Special Enrollment Notice | 3 |
| Statement of ERISA Rights | 3 |
| Introduction | 5 |
| Welcome to Anthem! | 5 |
| How to Get Language Assistance | 5 |
| Table of Contents..... | 6 |
| Schedule of Benefits – Anthem Preferred DirectAccess - gvea..... | 11 |
| How Your Plan Works..... | 27 |
| Introduction..... | 27 |
| In-Network Services | 27 |
| Out-of-Network Services | 27 |
| How to Find a Provider in the Network..... | 28 |
| Continuity of Care..... | 28 |
| Your Cost-Shares | 28 |
| Crediting Prior Plan Coverage..... | 29 |
| The BlueCard Program..... | 29 |
| Identification Card..... | 30 |
| Getting Approval for Benefits..... | 31 |
| Types of Requests..... | 31 |
| Request Categories..... | 32 |
| Decision and Notice Requirements | 33 |
| Individual Case Management..... | 34 |
| What's Covered | 35 |
| Allergy Services..... | 35 |
| Ambulance Services..... | 35 |
| Important Notes on Air Ambulance Benefits..... | 36 |
| Autism Services..... | 36 |
| Behavioral Health Services | 37 |
| Breast Cancer Treatment | 37 |
| Cardiac Rehabilitation | 37 |
| Chemotherapy | 37 |
| Chiropractor Services | 37 |
| Clinical Trials | 37 |
| Congenital Defects and Birth Abnormalities..... | 38 |
| Dental Services | 38 |
| Preparing the Mouth for Medical Treatments | 38 |
| Treatment of Accidental Injury..... | 39 |
| Other Dental Services..... | 39 |
| Diabetes Equipment, Education, and Supplies | 39 |
| Diagnostic Services | 39 |

| | |
|---|----|
| Diagnostic Laboratory and Pathology Services | 39 |
| Diagnostic Imaging Services and Electronic Diagnostic Tests | 39 |
| Advanced Imaging Services | 39 |
| Dialysis | 40 |
| Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies | 40 |
| Durable Medical Equipment and Medical Devices | 40 |
| Hearing Aids and Related Services for Members Under Age 18 | 40 |
| Orthotics | 40 |
| Prosthetics | 41 |
| Medical and Surgical Supplies | 41 |
| Blood and Blood Products | 41 |
| Emergency Care Services | 41 |
| Emergency Services | 41 |
| Home Care Services | 42 |
| Home Infusion Therapy | 43 |
| Hospice Care | 43 |
| Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services | 43 |
| Prior Approval and Precertification | 44 |
| Inpatient Services | 46 |
| Inpatient Hospital Care | 46 |
| Inpatient Professional Services | 46 |
| Maternity and Reproductive Health Services | 46 |
| Maternity Services | 46 |
| Endometriosis and Endometritis | 47 |
| Contraceptive Benefits | 47 |
| Sterilization Services | 47 |
| Abortion Services | 47 |
| Infertility Services | 47 |
| Mental Health and Substance Abuse Services | 47 |
| Occupational Therapy | 48 |
| Office Visits and Doctor Services | 48 |
| Orthotics | 49 |
| Outpatient Facility Services | 49 |
| Physical Therapy | 49 |
| Preventive Care | 49 |
| Prosthetics | 50 |
| Pulmonary Therapy | 50 |
| Radiation Therapy | 50 |
| Rehabilitation Services | 50 |
| Habilitative Services | 51 |
| Respiratory Therapy | 51 |
| Skilled Nursing Facility | 51 |
| Smoking Cessation | 51 |
| Speech Therapy | 51 |
| Surgery | 51 |
| Oral Surgery | 51 |
| Reconstructive Surgery | 52 |
| Temporomandibular Joint (TMJ) and Craniomandibular Joint Services | 52 |
| Therapy Services | 52 |
| Physical Medicine Therapy Services | 52 |
| Other Therapy Services | 53 |
| Transplant Services | 53 |
| Urgent Care Services | 53 |
| Vision Services For Members Through Age 20 | 54 |
| Routine Eye Exam | 54 |

| | |
|---|-----------|
| Eyeglass Lenses..... | 54 |
| Frames..... | 54 |
| Contact Lenses..... | 54 |
| Vision Services (All Members / All Ages)..... | 54 |
| Prescription Drugs Administered by a Medical Provider | 55 |
| Important Details About Prescription Drug Coverage..... | 55 |
| Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy | 56 |
| Prescription Drug Benefits..... | 56 |
| Covered Prescription Drugs..... | 56 |
| Where You Can Get Prescription Drugs..... | 57 |
| What You Pay for Prescription Drugs..... | 58 |
| Additional Features of Your Prescription Drug Pharmacy Benefit..... | 58 |
| What's Not Covered | 60 |
| What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit..... | 64 |
| Additional Information About Experimental / Investigational Services | 66 |
| Claims Payment | 68 |
| Maximum Allowed Amount..... | 68 |
| General..... | 68 |
| Notice of Claim & Proof of Loss | 71 |
| Claim Forms | 72 |
| Member's Cooperation | 72 |
| Payment of Benefits | 72 |
| Out-of-Area Services | 72 |
| BlueCard® Program | 73 |
| Non-Participating Healthcare Providers Outside Our Service Area | 73 |
| Coordination of Benefits When Members Are Insured Under More Than One Plan..... | 74 |
| Applicability..... | 74 |
| Definitions..... | 74 |
| Order of Benefit Determination Rules | 75 |
| Effect on this Plan's Benefits..... | 77 |
| Right to Receive and Release Needed Information..... | 77 |
| Facility of Payment..... | 77 |
| Right of Recovery..... | 78 |
| Subrogation and Reimbursement | 79 |
| Subrogation..... | 79 |
| Reimbursement..... | 79 |
| Your Duties..... | 80 |
| Your Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member..... | 81 |
| Complaint and Appeals Process | 83 |
| The Complaint Process | 83 |
| The Appeals Process | 83 |
| Expedited Appeals..... | 85 |
| External Review by an Independent Review Entity..... | 85 |
| Expedited External Reviews | 86 |
| The Decision of the Independent Review Entity..... | 87 |
| Who to Contact for Appeals and External Review | 87 |
| Kentucky Health Insurance Advocate | 88 |
| Medical Services | 88 |
| Limitation of Actions | 88 |
| Eligibility and Enrollment – Adding Members..... | 89 |

| | |
|--|------------|
| Who is Eligible for Coverage | 89 |
| The Subscriber..... | 89 |
| Dependents..... | 89 |
| Types of Coverage..... | 90 |
| When You Can Enroll | 90 |
| Initial Enrollment | 90 |
| Open Enrollment..... | 90 |
| Special Enrollment Periods..... | 90 |
| Special Rules if Your Group Health Plan is Offered Through an Exchange | 90 |
| Medicaid and Children's Health Insurance Program Special Enrollment..... | 91 |
| Late Enrollees | 91 |
| Members Covered Under the Group's Prior Plan..... | 91 |
| Enrolling Dependent Children | 91 |
| Newborn Children | 91 |
| Adopted Children | 92 |
| Adding a Child due to Award of Legal Custody or Guardianship | 92 |
| Qualified Medical Child Support Order | 92 |
| Updating Coverage and/or Removing Dependents | 92 |
| Nondiscrimination | 92 |
| Statements and Forms | 93 |
| Termination and Continuation of Coverage | 94 |
| Termination..... | 94 |
| Removal of Members | 94 |
| Certification of Prior Creditable Coverage..... | 94 |
| Special Rules if Your Group Health Plan is Offered Through an Exchange | 95 |
| Continuation of Coverage Under Federal Law (COBRA)..... | 95 |
| Qualifying events for Continuation Coverage under Federal Law (COBRA)..... | 95 |
| If Your Group Offers Retirement Coverage | 96 |
| Second qualifying event..... | 96 |
| Notification Requirements..... | 96 |
| Disability extension of 18-month period of continuation coverage | 97 |
| Trade Adjustment Act Eligible Individual | 97 |
| When COBRA Coverage Ends..... | 97 |
| If You Have Questions | 97 |
| Continuation of Coverage Under Kentucky Law | 98 |
| Conversion | 98 |
| Continuation of Coverage Due To Military Service | 99 |
| Maximum Period of Coverage During a Military Leave | 99 |
| Reinstatement of Coverage Following a Military Leave | 99 |
| College Student Medical Leave..... | 100 |
| Family and Medical Leave Act of 1993 | 100 |
| Benefits After the Group Contract Ends | 100 |
| General Provisions | 102 |
| Assignment..... | 102 |
| Clerical Error..... | 102 |
| Confidentiality and Release of Information..... | 102 |
| Conformity with Law | 102 |
| Contract with Anthem | 102 |
| Entire Contract..... | 103 |
| Form or Content of Booklet | 103 |
| Government Programs | 103 |
| Medical Policy and Technology Assessment | 103 |
| Medicare | 103 |
| Modifications..... | 104 |
| Not Liable for Provider Acts or Omissions..... | 104 |

| | |
|--|------------|
| Policies and Procedures..... | 104 |
| Relationship of Parties (Group-Member-Anthem)..... | 104 |
| Relationship of Parties (Anthem and In-Network Providers)..... | 104 |
| Reservation of Discretionary Authority | 105 |
| Right of Recovery | 105 |
| Unauthorized Use of Identification Card..... | 105 |
| Value-Added Programs | 106 |
| Value of Covered Services | 106 |
| Voluntary Wellness Incentive Programs..... | 106 |
| Waiver..... | 106 |
| Workers' Compensation | 106 |
| Definitions..... | 107 |

Schedule of Benefits – Anthem Preferred DirectAccess - gvea

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. |
|----------------------------|--|

| Deductible | In-Network | Out-of-Network |
|--|-------------------|-----------------------|
| Per Member | \$500 | \$1,000 |
| Per Family – All other Members combined | \$1,500 | \$3,000 |
| <p>The In-Network and Out-of-Network Deductibles are separate and cannot be combined.</p> <p>When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.</p> <p>Copayments and Coinsurance are separate from and do not apply to the Deductible.</p> | | |

| Coinsurance | In-Network | Out-of-Network |
|--|-------------------|-----------------------|
| Plan Pays | 80% | 60% |
| Member Pays | 20% | 40% |
| <p>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.</p> <p>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.</p> | | |

| Out-of-Pocket Limit | In-Network | Out-of-Network |
|---|-------------------|-----------------------|
| Per Member | \$5,500 | \$13,750 |
| Per Family – All other Members combined | \$11,000 | \$27,500 |
| <p>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.</p> <p>The Out-of-Pocket Limit does not include amounts you pay for following benefits:</p> <ul style="list-style-type: none"> • Out-of-Network Human Organ and Tissue Transplant services. <p>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.</p> <p>The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.</p> | | |

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) | 20% Coinsurance after Deductible 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. | |
| Ambulance Services (Ground) | 20% Coinsurance after Deductible 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. | |
| Autism Services | Benefits are based on the setting in which Covered Services are received. Autism Services Benefit Maximum For Members age 1 through 21 20 hours per month In- and Out-of-Network combined The Benefit Maximum listed above only applies to Autism Services. It does not apply to the Member's other health conditions or to Covered Services not related to Autism Services. | |
| Behavioral Health Services | See "Mental Health and Substance Abuse Services." | |
| Cardiac Rehabilitation | See "Therapy Services." | |

| Benefits | In-Network | Out-of-Network |
|--|---|----------------------------------|
| Chemotherapy | See "Therapy Services." | |
| Chiropractor Services | See "Therapy Services." | |
| Clinical Trials | Benefits are based on the setting in which Covered Services are received. | |
| Congenital Defects and Birth Abnormalities | Benefits are based on the setting in which Covered Services are received. | |
| Dental Services Dental Services Accidental Injury Benefit Maximum for Members Age 21 and Older | Benefits are based on the setting in which Covered Services are received. \$3,000 per accident In- and Out-of-Network combined. This limit will not apply to outpatient Facility charges, anesthesia billed by a Provider other than the Doctor performing the service, or to services we are required to cover by law. | |
| 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 after Deductible | 40% 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. | | |

| Benefits | In-Network | Out-of-Network |
|--|---|-------------------------------------|
| Hearing Aid Benefit Maximum for Members under 18 years of age: | One hearing aid per ear every 36 months In- and Out-of-Network combined | |
| Wigs Needed After Cancer Treatment Benefit Maximum | One wig per Benefit Period In- and Out-of-Network combined | |
| Emergency Room Services | | |
| Emergency Room | | |
| <ul style="list-style-type: none"> Emergency Room Facility Charge | \$200 Copayment per visit plus 20% Coinsurance Copayment waived if admitted | |
| <ul style="list-style-type: none"> Emergency Room Doctor Charge | 20% Coinsurance after Deductible | |
| <ul style="list-style-type: none"> Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) | 20% Coinsurance after Deductible | |
| <ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) | 20% Coinsurance after Deductible | |
| Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount. | | |
| Home Care | | |
| <ul style="list-style-type: none"> Home Care Visits | \$25 Copayment per visit | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Home Dialysis | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Home Infusion Therapy | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Specialty Prescription Drugs | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Other Home Care Services / Supplies | 20% Coinsurance after Deductible | 40% 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 Benefit Maximum | 2,000 hours per Benefit Period, In- and Out- of-Network combined. | |
| Home Infusion Therapy | | |
| | | See "Home Care." |

| Benefits | In-Network | Out-of-Network |
|--|--|---|
| <p>Hospice Care</p> <ul style="list-style-type: none"> • Home Care • Respite Hospital Stays <p style="text-align: right;">No Copayment, Deductible, or Coinsurance</p> <p>Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.</p> <p>This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit.</p> | | |
| <p>Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services</p> | | |
| <p>Please see the separate summary later in this section.</p> | | |
| <p>Inpatient Services</p> <p>Facility Room & Board Charge:</p> <ul style="list-style-type: none"> • Hospital / Acute Care Facility • Skilled Nursing Facility <p style="padding-left: 40px;">Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum</p> <p>Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)</p> <p>Doctor Services for:</p> <ul style="list-style-type: none"> • General Medical Care / Evaluation and Management (E&M) • Surgery | | |
| <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <p>20% Coinsurance after Deductible</p> | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <p>150 days per Benefit Period In- and Out-of-Network combined.</p> | | |
| <p>20% Coinsurance after Deductible</p> | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <p>20% Coinsurance after Deductible</p> | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <p>20% Coinsurance after Deductible</p> | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <p>Maternity and Reproductive Health Services</p> | | |
| <ul style="list-style-type: none"> • Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <ul style="list-style-type: none"> • Inpatient Services (Delivery) | <p style="text-align: center;">See "Inpatient Services."</p> | |
| <p>Mental Health and Substance Abuse Services</p> | | |
| <ul style="list-style-type: none"> • Inpatient Facility Services | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <ul style="list-style-type: none"> • Residential Treatment Center Services | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |
| <ul style="list-style-type: none"> • Inpatient Doctor Services | <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> |

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| <ul style="list-style-type: none"> • Outpatient Facility Services • Outpatient Doctor Services • Partial Hospitalization Program / Intensive Outpatient Services • Office Visits | <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>\$25 Copayment per visit</p> | <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> |
| <p>Mental Health and Substance Abuse 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.</p> | | |
| Occupational Therapy | | See “Therapy Services.” |
| Office Visits | | |
| • Primary Care Physician / Provider (PCP) | \$25 Copayment per visit | 40% Coinsurance after Deductible |
| • Specialty Care Physician / Provider (SCP) | \$50 Copayment per visit | 40% Coinsurance after Deductible |
| • Retail Health Clinic Visit | \$15 Copayment per visit | 40% Coinsurance after Deductible |
| • Online Visit | \$25 Copayment per visit | 40% Coinsurance after Deductible |
| • Nutritional Counseling | \$15 Copayment per visit | 40% Coinsurance after Deductible |
| • Allergy Testing | \$15 Copayment per visit | 40% Coinsurance after Deductible |
| • Allergy Shots / Injections (other than allergy serum) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| • Preferred Diagnostic Labs (i.e., reference labs) | No Copayment, Deductible, or Coinsurance | 40% Coinsurance after Deductible |
| • Diagnostic Lab (non-preventive) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| • Diagnostic X-ray (non-preventive) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| • Diagnostic Tests (non-preventive; including hearing and EKG) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| • Advanced Diagnostic Imaging (including MRIs, CAT scans) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |

| Benefits | In-Network | Out-of-Network |
|--|---|---|
| <ul style="list-style-type: none"> • Office Surgery • Therapy Services: <ul style="list-style-type: none"> - Chiropractic Care & Spinal Manipulation* - Physical, Speech, & Occupational Therapy* - Dialysis / Hemodialysis - Radiation / Chemotherapy / Non-Preventive Infusion & Injection - Cardiac Rehabilitation & Pulmonary Therapy <p>See "Therapy Services" for details on Benefit Maximums.</p> <p>*If you get Covered Services from a Chiropractor, Physical Therapist, or Occupational Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician.</p> <ul style="list-style-type: none"> • Prescription Drugs Administered in the Office (includes allergy serum) | <p>\$50 Copayment per visit</p> <p>\$25 Copayment per visit</p> <p>\$25 Copayment per visit</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>\$50 Copayment per visit</p> <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> |
| Orthotics | See "Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies." | |
| Outpatient Facility Services | | |
| <ul style="list-style-type: none"> • Facility Surgery Charge • Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies) • Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant) • Other Facility Charges (for procedure rooms or other ancillary services) • Diagnostic Lab • Diagnostic X-ray | <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> | <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> |

| Benefits | In-Network | Out-of-Network |
|--|---|-------------------------------------|
| <ul style="list-style-type: none"> Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive) Advanced Diagnostic Imaging (including MRIs, CAT scans) Therapy: <ul style="list-style-type: none"> Chiropractic Care & Spinal Manipulation* Physical, Speech, & Occupational* Radiation / Chemotherapy / Non-Preventive Infusion & Injection Dialysis / Hemodialysis Cardiac Rehabilitation & Pulmonary Therapy <p>See "Therapy Services" for details on Benefit Maximums.</p> <p>If you get Covered Services from a Chiropractor, Physical Therapist, or Occupational Therapist, you will not have to pay an outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician.</p> | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Prescription Drugs Administered in an Outpatient Facility | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| Physical Therapy | See "Therapy Services." | |
| Preventive Care | No Copayment, Deductible, or Coinsurance | 40% 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. | |

| Benefits | In-Network | Out-of-Network |
|--|---|---|
| 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. | |
| Temporomandibular and Craniomandibular Joint Treatment | Benefits are based on the setting in which Covered Services are received. | |
| <p data-bbox="183 615 410 646">Therapy Services</p> <p data-bbox="183 909 435 940">Benefit Maximum(s):</p> <ul data-bbox="183 1035 500 1308" style="list-style-type: none"> <li data-bbox="183 1035 443 1066">• Physical Therapy <li data-bbox="183 1098 500 1129">• Occupational Therapy <li data-bbox="183 1161 435 1192">• Speech Therapy <li data-bbox="183 1224 492 1255">• Manipulation Therapy <li data-bbox="183 1287 500 1318">• Cardiac Rehabilitation <p data-bbox="183 1350 1482 1402">Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.</p> <p data-bbox="183 1434 1466 1486">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.</p> | Benefits are based on the setting in which Covered Services are received. | <p data-bbox="979 909 1482 1003">Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.</p> <ul data-bbox="1068 1035 1385 1308" style="list-style-type: none"> <li data-bbox="1068 1035 1385 1066">20 visits per Benefit Period <li data-bbox="1068 1098 1385 1129">20 visits per Benefit Period <li data-bbox="1068 1161 1385 1192">20 visits per Benefit Period <li data-bbox="1068 1224 1385 1255">20 visits per Benefit Period <li data-bbox="1068 1287 1385 1318">36 visits per Benefit Period |
| Transplant Services | See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services." | |
| <p data-bbox="183 1707 638 1738">Urgent Care Services (Office Visits)</p> <ul data-bbox="183 1759 613 1864" style="list-style-type: none"> <li data-bbox="183 1759 613 1791">• Urgent Care Office Visit Charge <li data-bbox="183 1833 410 1864">• Allergy Testing | <p data-bbox="979 1759 1206 1812">\$50 Copayment per visit</p> <p data-bbox="979 1833 1206 1885">\$50 Copayment per visit</p> | <p data-bbox="1271 1759 1482 1812">40% Coinsurance after Deductible</p> <p data-bbox="1271 1833 1482 1885">40% Coinsurance after Deductible</p> |

| Benefits | In-Network | Out-of-Network |
|---|--|---|
| <ul style="list-style-type: none"> Allergy Shots / Injections (other than allergy serum) | \$50 Copayment per visit | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Preferred Diagnostic Labs (i.e., reference labs) | No Copayment, Deductible, or Coinsurance | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Other Charges (e.g., diagnostic x-ray and lab services, medical supplies) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Office Surgery | \$50 Copayment per visit | 40% Coinsurance after Deductible |
| <ul style="list-style-type: none"> Prescription Drugs Administered in the Office (includes allergy serum) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <p>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.</p> | | |
| <p>Vision Services For Members Through Age 20</p> | | |
| <p>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.</p> | | |
| <ul style="list-style-type: none"> Routine Eye Exam <p>Limited to one exam per Benefit Period</p> | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| <ul style="list-style-type: none"> Standard Plastic Lenses <p>Limited to one set of lenses per Benefit Period plus one set of replacement lenses if Medically Necessary. Available only if the contact lenses benefit is not used.</p> | | |
| <p>Single Vision</p> | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| <p>Bifocal</p> | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| <p>Trifocal</p> | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| <p>Progressive</p> | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| <p>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.</p> | | |

| Benefits | In-Network | Out-of-Network |
|---|--|---|
| <ul style="list-style-type: none"> Frames Limited to one set of frames from the Anthem formulary per Benefit Period plus one set of replacement frames if Medically Necessary. Contact Lenses Limited to one set of contact lenses from the Anthem formulary per Benefit Period. Available only if the eyeglass lenses benefit is not used. | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| Elective Contact Lenses (Conventional or Disposable) | \$0 Copayment | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| Non-Elective Contact Lenses | No Copayment, Deductible, or Coinsurance | \$0 Copayment up to the Plan's Maximum Allowed Amount |
| 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. If you get Covered Services from an Optometrist, you will not have to pay a Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. | | Benefits are based on the setting in which Covered Services are received. |

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

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

The requirements described below do not apply to the following:

- Cornea and kidney transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

| Transplant Benefit Period | In-Network Transplant Provider | Out-of-Network Transplant Provider |
|--|---|---|
| | <p>Starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.</p> | <p>Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of- Network Transplant Provider Facility.</p> |
| Covered Transplant Procedure during the Transplant Benefit Period | In-Network Transplant Provider Facility | Out-of-Network Transplant Provider Facility |
| <ul style="list-style-type: none"> • Precertification required | <p>During the Transplant Benefit Period, no Copayment / Deductible / Coinsurance.</p> | <p>During the Transplant Benefit Period, You will pay 50% Coinsurance after Deductible.</p> |
| | <p>Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.</p> | <p>During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.</p> |
| | | <p>If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.</p> |
| | | <p>If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant</p> |

| | | |
|--|--|---|
| | | Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed. |
| Covered Transplant Procedure during the Transplant Benefit Period | In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers | Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers |
| | No Copayment / Deductible / Coinsurance | 50% Coinsurance after Deductible |
| | | These charges will NOT apply to your Out-of-Pocket Limit. |
| Transportation and Lodging | No Copayment / Deductible / Coinsurance | Not covered |
| <ul style="list-style-type: none"> Transportation and Lodging Limit | Covered, as approved by us, up to \$10,000 per transplant In-Network only. Benefits are not available Out-of-Network. | |
| Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure | No Copayment / Deductible / Coinsurance | 50% Coinsurance after Deductible |
| | | These charges will NOT apply to your Out-of-Pocket Limit. |
| <ul style="list-style-type: none"> Donor Search Limit | Covered, as approved by us, up to \$30,000 per transplant In- and Out-of-Network combined. | |
| Live Donor Health Services | No Copayment / Deductible / Coinsurance | 50% Coinsurance after Deductible. |
| | | These charges will NOT apply to your Out-of-Pocket Limit. |
| <ul style="list-style-type: none"> 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. | |

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. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.

Prescription Drug Deductible

(Does not apply to Tier 1)

| | |
|------------|---------------------------------------|
| Per Member | \$250 In- and Out-of-Network combined |
| Per Family | \$500 In- and Out-of-Network combined |

Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan. You must pay the Deductible before you pay any Copayments / Coinsurance listed below.

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 | \$10 Copayment per Prescription Drug | 50% Coinsurance |
| Tier 2 Prescription Drugs | \$30 Copayment per Prescription Drug | 50% Coinsurance |
| Tier 3 Prescription Drugs | \$60 Copayment per Prescription Drug | 50% Coinsurance |
| Tier 4 Prescription Drugs | 25% Coinsurance to a maximum of \$250 per Prescription Drug | 50% Coinsurance |

Home Delivery Pharmacy Copayments / Coinsurance:

| | | |
|---------------------------|--------------------------------------|-------------|
| Tier 1 Prescription Drugs | \$25 Copayment per Prescription Drug | Not covered |
|---------------------------|--------------------------------------|-------------|

| Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits | In-Network | Out-of-Network |
|--|---|-----------------------|
| Tier 2 Prescription Drugs | \$75 Copayment per Prescription Drug | Not covered |
| Tier 3 Prescription Drugs | \$150 Copayment per Prescription Drug | Not covered |
| Tier 4 Prescription Drugs | 25% Coinsurance to a maximum of \$250 per Prescription Drug | Not covered |

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. If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug. 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.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

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 complete 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.

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.

If an Out-of-Network Provider meets our enrollment criteria and is willing to meet the terms and conditions of our Provider agreement, that Provider has the right to become an In-Network Provider for this Plan. They will not become an In-Network Provider, however, until they have signed the required Provider agreement.

Continuity of Care

If your In-Network Provider leaves our network, you may be able to continue seeing that Provider for a limited time and still get In-Network benefits. This could happen if you have a disability, a congenital condition, or a life-threatening illness. It also could occur if you are pregnant, past the 24th week of pregnancy, and if changing to another In-Network Provider could result in harm. If you wish to continue seeing the same Provider, you or your Doctor should contact Customer Service for details.

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.

For the Deductible, the credit applies for the same or overlapping benefit periods and will be given for costs you paid toward the deductible of the Group's prior carrier or plan in the 90 days before the Group's effective date with us. You will also receive credit for any satisfaction or partial satisfaction of waiting periods under the Group's prior carrier or 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. Covered Services must be Medically Necessary for benefits to be covered.

Prior Authorization: In-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 a Covered Service 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 24 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 | <ul style="list-style-type: none"> • 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 an Emergency admission. For Emergency admissions, you, your authorized representative or Doctor must tell us within 24 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 policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. 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 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 | 24 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 | 24 hours 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 email 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 Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. **For services to be covered, they must be provided in the least costly setting that is medically appropriate.** The costs of services will often vary depending on the setting you choose, and the choice of setting can result in a change in the amount you need to pay or even in a denial for the services. Please see the "Schedule of Benefits" and the "Getting Approval for Benefits" sections 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.**

Autism Services

Your Plan also covers the diagnosis and treatment of Autism Spectrum Disorders for Members ages 1 through 21. Autism Spectrum Disorders are a physical, mental, or cognitive illness or disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). They include any of the pervasive developmental disorders, Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Benefits for Members diagnosed with an Autism Spectrum Disorder include the following:

1. Medical care from by a licensed Provider.
2. Habilitative or rehabilitative care. This includes counseling and guidance services, therapy, treatment programs, and applied behavior analysis.
3. Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy, if this Plan includes Pharmacy benefits, and Medically Necessary services to determine the need or effectiveness of the Drugs.
4. Psychiatric care.
5. Psychological care given by a licensed Provider.
6. Therapy from licensed speech therapists, occupational therapists, or physical therapists; and

7. Applied behavior analysis prescribed or ordered by a licensed Provider.

No benefits are available under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Given to the Member by a publicly funded program;
- Given by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services given by people who are not licensed as required by law.

Behavioral Health Services

See “Mental Health and Substance Abuse Services” later in this section.

Breast Cancer Treatment

This Plan covers services to treat breast cancer including chemotherapy, high-dose chemotherapy with autologous bone marrow transplants or stem cell transplants, mastectomies, prosthetics, and reconstructive services needed after the mastectomy. Please see the rest of the Booklet for details on how each benefit is covered.

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.

Congenital Defects and Birth Abnormalities

Covered Services include the treatment of medically-diagnosed congenital defects and birth abnormalities.

Dental Services

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.

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

Other Dental Services

The Plan will also cover Hospital or Ambulatory Surgical Facility charges and anesthesia for dental care if the Member is:

1. Under the age of nineteen (19),
2. Has a serious mental or physical condition; or
3. Has significant behavioral problems.

The Member's Provider must certify that hospitalization or general anesthesia is required to safely and effectively give the dental care. Benefits do not include routine dental care or treatment of dental conditions not covered by the Plan.

Diabetes Equipment, Education, and Supplies

Benefits are available for medical services, supplies, equipment, insulin, and Prescription Drugs needed to treat diabetes. Covered Services also include diabetic self-management training and education programs, including medical nutrition therapy.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)

- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

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.

Hearing Aids and Related Services for Members Under Age 18

Benefits include hearing aids for Members under age 18. Benefits also include services to assess, select, adjust or fit the hearing aid. You can get Covered Services from a licensed audiologist or a licensed hearing instrument specialist.

Orthotics

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

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

- For Members under age 18, when needed as a result of rapid growth, or
- For Members of any age, when an appliance is damaged and cannot be repaired.

Prosthetics

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

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

- 1) Artificial limbs and accessories;
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) 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.

Blood and Blood Products

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

Emergency Care Services

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
- Private duty nursing services.

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

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 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.

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

In this section you will see some key terms, which are 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.

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

Any Provider that has **NOT** has been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by a designee.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

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

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the 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:

- 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.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

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

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;

- Prenatal and postnatal services; 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.

Endometriosis and Endometritis

Your Plan also covers the diagnosis and treatment of endometriosis and endometritis.

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 performed to save the life or health of the mother. Elective abortions are not a Covered Service.

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 Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation.
- **Outpatient Services** including treatment in an outpatient department of a Hospital and office visits.
- **Day Treatment Services** which are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital.
- **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 Abuse Facility, or
- Other Facilities approved by us.

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

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

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 health problem.

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

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; 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, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered 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.

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>.

Covered Services also include these services as required by state law:

- Routine bone density testing for women.
- Routine colorectal cancer exams and related lab tests.
- Routine screening mammograms.
- Annual pap smears for women.

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, 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 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.

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

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

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
- Prosthesis 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.

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. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **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.

Other Therapy Services

Benefits are also available for:

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

Transplant Services

See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” 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 Through Age 20

The vision benefits described in this section only apply to Members through age 20.

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. You may choose elective contact lenses in lieu of your eyeglass lenses benefit.
- 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.

Vision Services (All Members / All Ages)

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

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

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs 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 an appeal as outlined in the "Complaint and Appeals Process" 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.
- Therapeutic food, formulas, supplements, and low-protein modified food products needed to treat inborn errors of metabolism or genetic conditions when given under the direction of a Doctor. Prior Authorization is required.
- 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.

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.

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.
- 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.
- 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.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

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. You can get a copy of the Prescription Drug List by calling us or visiting our website at www.anthem.com.

If you or your Doctor believes you need a certain Prescription Drug not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the Drugs on the List. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

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) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery.

This Exclusion does not apply to therapeutic abortions, which are abortions performed to save the life or health of the mother.

- 2) **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 when you are a direct participant.

- 3) **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.

- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes:

- 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. Bioenergetic synchronization technique (BEST),
- n. Iridology-study of the iris,
- o. Auditory integration therapy (AIT),
- p. Colonic irrigation,
- q. Magnetic innervation therapy,

r. Electromagnetic therapy,

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.
- 7) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 8) **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.
- 9) **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 reconstructive surgery for breast symmetry after a mastectomy or to surgery to correct congenital defects and birth abnormalities.

- 10) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 11) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if you were the victim of a crime, including domestic violence.
- 12) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 13) **Dental Treatment** Dental treatment, except as listed below.

Excluded treatment includes 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.

- 14) **Educational Services** Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 15) **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 see "Additional Information about Experimental / Investigational Services" at the end of this section for more details.

- 16) **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.
- 17) **Eye Exercises** Orthoptics and vision therapy. This Exclusion does not apply to Members through age 20.
- 18) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

- 19) **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.
- 20) **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.
- 21) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
- 22) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 23) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes 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.
- This Exclusion does not apply to a Member incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.
- 24) **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. It also does not apply to hearing aids for children under age 18.
- 25) **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.
- 26) **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.
- 27) **Infertility Treatment** Testing or treatment related to infertility.
- 28) **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.
- 29) **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.
- 30) **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.

- 31) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 32) **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.
- 33) **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 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.
- 34) **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.
- 35) **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).
- 36) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.
- 37) **Prosthetics** Prosthetics for sports or cosmetic purposes.
- 38) **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.
- 39) **Sex Change** Services and supplies for a sex change and/or the reversal of a sex change.
- 40) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 41) **Smoking Cessation Programs** Programs to help you stop smoking if the program is not affiliated with Anthem.
- 42) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 43) **Sterilization** Services to reverse an elective sterilization.
- 44) **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).
- 45) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 46) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 47) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

48) **Vision Services**

- a) Vision services for Members age 21 or older, unless listed as covered in this Booklet.
- b) Safety glasses and accompanying frames.
- c) For two pairs of glasses in lieu of bifocals.
- d) Plano lenses (lenses that have no refractive power)
- e) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period. This Exclusion does not apply, however, to one set of replacement lenses or frames if they are Medically Necessary.
- f) Vision services not listed as covered in this Booklet.
- g) Cosmetic lenses or options.
- h) Blended lenses.
- i) Oversize lenses.
- j) Sunglasses and accompanying frames.
- k) For services or supplies combined with any other offer, coupon or in-store advertisement.
- l) For Members through age 20, no benefits are available for frames not on the Anthem formulary.
- m) Certain frames in which the manufacturer imposes a no discount policy.

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

This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

50) **Weight Loss Surgery** Bariatric surgery. This includes 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 Gastropasty, (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. If you or your Doctor believes you need a

certain Prescription Drug not on the list, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the Drugs on the List. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

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.
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 Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-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.

Additional Information About Experimental / Investigational Services

We will find any Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply (i.e., any service or supply) to be Experimental / Investigational if we find that one or more of the following criteria apply when the service or supply is given:

- It cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- It has been determined by the FDA to be contraindicated for the specific use; or
- It is given as part of a clinical research protocol or clinical trial or is given in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service or supply; or
- It is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- It is given as part of informed consent documents that describe the service or supply as Experimental / Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the service or supply is under evaluation.

Any service or supply not deemed Experimental / Investigational based on the criteria above may still be deemed Experimental / Investigational by us. In determining whether a service or supply is Experimental / Investigational, we will consider the information described below and assess whether:

- the scientific evidence is conclusive concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigational settings.

The information we consider or evaluate to determine whether a service or supply is Experimental / Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same service or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will apply our medical policy to identify and weigh all information and determine all questions about whether a service or supply is Experimental / Investigational.

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.

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

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.

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. We also may authorize the In-Network cost share amounts to apply to a claim for Covered Services if you receive Emergency services from an Out-of-Network Provider and are not able to contact us until after the Covered Service is rendered. If we authorize an In-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

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. Claims will be paid within 30 days of the date we get the completed claim and proof of loss.

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. 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. Please note that once we become aware of your eligibility for Medicare, we will pay claims as if you had enrolled in Medicare, even if you did not.

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. 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.

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 Allowable 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

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. Group insurance or group-type coverage whether insured or uninsured. This shall not include the medical benefits coverage in a group, group-type, and individual motor vehicle "no-fault" and traditional automobile "fault" type contracts. This does include prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.
3. Coverage under a governmental Plan or coverage required or provided by law except Medicare or Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" does not include any of the following:

1. Group or group-type Hospital indemnity benefits of \$100.00 per day or less.
2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

Primary plan means a plan whose benefits shall be determined without taking the existence of any other plan into consideration if:

1. The plan either has no order of benefits determination requirements, or

2. All plans that cover the person use the order of benefits determination requirements as listed in the Order of Benefit Determination Rules section.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a health care service or expense including Deductibles, Coinsurance or Copayment, that is covered in full or in part by any of the plans covering the person.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and Preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its Contract, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

Claim Determination Period - means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether over-insurance exists and how much each Plan will pay or provide.

Benefit Reserve - means the savings recorded by a Plan for claims paid for a Member as a Secondary Plan rather than as a Primary Plan

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Subscriber or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:
 - A. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 2. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
 - B. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 1. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 2. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 4. If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - a. The Plan covering the Custodial parent;
 - b. The Plan covering the spouse of the Custodial parent;
 - c. The Plan covering the non-custodial parent; and then
 - d. The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.
4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.
5. Active/Inactive Subscriber. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If

the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.

6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
 - a. First, the benefits of a Plan covering the person as an employee, Subscriber or Subscriber or as that person's Dependent;
 - b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable Expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense.

When this Plan is Secondary, you will receive credit during the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. A combined benefit from all Plans greater than the Allowable Expense; or
2. More benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, any Benefit Reserve accumulated for a Member will be used to pay Allowable Expenses of that Member only, not otherwise paid during the Claim Determination Period. The Benefit Reserve, if any, will return to zero at the end of the Claim Determination Period.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give us any facts we need to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan is more than it should have paid under this provision, we may recover the excess from one or more of:

1. The persons we have paid or for whom we paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery. A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the full amount of benefits we have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full our subrogation claim and any claim still held by you, our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs you incur without our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.

Reimbursement

If you obtain a Recovery and we have not been repaid for the benefits we paid on your behalf, we shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse us to the extent of benefits we paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, we shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to us immediately upon your receipt of the Recovery. You must reimburse us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount we paid on your behalf is not repaid or otherwise recovered by us; or
 2. You fail to cooperate.
- In the event that you fail to disclose to us the amount of your settlement, we shall be entitled to deduct the amount of our lien from any future benefit under the Plan.

- We shall also be entitled to recover any of the unsatisfied portion of the amount we have paid or the amount of your settlement, whichever is less, directly from the Providers to whom we have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and we would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with us in the investigation, settlement and protection of our rights.
- You must not do anything to prejudice our rights.
- You must send us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify us if you retain an attorney or if a lawsuit is filed on your behalf.

Your Rights and Responsibilities as an Anthem Blue Cross and Blue Shield Member

As an Anthem Blue Cross and Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights" and helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, 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, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your Plan and in the way your 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; and the right to have your doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with our policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you have to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals 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 professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all Plan rules and policies.
- Let our customer service department know if you have any changes to your name, address or family members covered under your Plan.

- 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 care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read the rest of this Booklet.

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.

Complaint and Appeals Process

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

(If you need assistance in Spanish to understand this document, you may request it for free by calling Customer Service at the number on Your Identification Card.)

Our customer service representatives are specially trained to answer your questions about our health plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Deductible, Coinsurance, or Copayment amounts;
- Specific claims or services you have received;
- Doctors or Hospitals in the network;
- Authorizations; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the appeals process. A complaint process also exists to help you understand the Plan's determinations.

The Complaint Process

A complaint procedure is available to provide reasonable, informative responses to complaints that you may have about us. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from us of our procedures and contracts. We invite you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Providers in our networks.

If you have a complaint or problem concerning benefits or services, please contact us. Please refer to your Identification Card for our address and telephone number. You may send in your complaint by letter or by phone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Process

An appeal is a formal request from you that asks us to change a previous determination. If you are notified in writing of any Adverse Determination or Coverage Denial, you will be advised of your right to an internal appeal and an external review if appropriate. You also have a right to appeal if we fail to make a Utilization Review determination and provide written notice within the required time frame. For purposes of this section:

- Coverage Denial means our determination that a service, treatment, Drug or device is specifically limited or excluded under this Booklet.
- Adverse Determination means our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:
 - A determination that you are not eligible to participate in the Plan, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a utilization review;

- A determination that the benefit is Experimental / Investigational or not Medically Necessary;
- A determination that the benefit is not a covered benefit under the Plan; or
- A determination that the benefit is excluded due to a limitation in the Plan.

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

The internal appeals process may be initiated by you, your authorized representative, or a Provider acting on your behalf within 60 days of the date you get our written notice of an Adverse Determination, a Coverage Denial or any other adverse decision we made, but must be filed within six months of the date you get the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by you relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the appeal.

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

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

If a representative is seeking an appeal on your behalf, we must get a signed Designation of Representation (DOR) form from you. The appeal process will not begin until we get the properly completed DOR form. The only exception to this is if a Physician requests an expedited internal appeal on your behalf, the Physician will be deemed to be your representative for the purpose of filing the expedited internal appeal even though we did not get the signed form. We will forward a Designation of Representation form to you to complete in all other situations.

We will ensure that appeals are reviewed in a manner designed to ensure the independence and partiality of the individuals responsible for reviewing your request (referred to as qualified reviewers). The qualified reviewers will not be the same people who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision. If the internal appeal is related to an Adverse Determination or any other adverse decision that is based in whole or in part on a medical judgment, at least one person conducting the appeal will be a licensed Physician (or if the determination involves services rendered by a Chiropractor or Optometrist, a Chiropractor or Optometrist licensed in Kentucky) unless a nurse can approve the request. If the appeal is related to a medical or surgical specialty or subspecialty, upon your request of the request of your authorized representative or Provider, at least one person conducting the appeal will be a board eligible or certified Physician in the appropriate specialty or subspecialty.

Within a reasonable time given the medical circumstances and no later than 30 days after we get a written or an oral request for appeal, we will send a written decision to you or your authorized representative and, if applicable, your Provider.

If we fail to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Expedited Appeals

An expedited appeal is deemed necessary when you are hospitalized, or in the opinion of the treating Provider (or any Physician with knowledge of your medical condition), review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the your health or, with respect to a pregnant woman, your health or your unborn child's health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions;
- Serious dysfunction of a bodily organ or part; or
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

In addition, Members in urgent care situations and Members receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

The Plan, applying a prudent lay person standard, may also determine that an appeal may be expedited. The request for an expedited internal appeal may be in writing or an oral request, followed up by an abbreviated written request by you, your authorized representative or Provider acting on your behalf. We have the right to require verification from the treating Provider (or other Physician with knowledge of your medical condition), that your condition warrants an expedited internal appeal.

The process for the expedited internal appeal is similar to the standard internal appeal, except that we will communicate our decision to you or your authorized representative as soon as possible taking into account the medical urgency of the situation, but no later than 72 hours after receipt of the request for an expedited internal appeal. All necessary information, including our decision on review, shall be transmitted between us and you or your authorized representative by phone, facsimile, or other available similarly expeditious method.

If our decision is to uphold a Coverage Denial, you, your authorized representative or a Provider acting on behalf of and with your consent may contact the Kentucky Department of Insurance, Health and Life Division, 215 W. Main Street, P.O. Box 517, Frankfort, KY 40602, and request a review of our decision. The Department will make a determination as to whether the service should or should not be covered. If the Department determines the disputed service should be covered, it may direct us to either pay the service or offer external review to resolve the issue.

External Review by an Independent Review Entity

You, your authorized representative, or a Provider acting on your behalf and with your consent may request an external review of an Adverse Determination if the following criteria are met:

- The internal appeal process outlined above was completed or jointly waived by you and us or we failed to make a decision within 30 days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and
- You were covered under this Plan on the date of service or, if a prospective denial, you were eligible to receive benefits under this Plan on the date the proposed service was requested.

The request for an external review of an Adverse Determination must be sent to us within 4 months of the date you get our written decision rendered under the internal appeals process. As part of the request, you shall provide written consent authorizing the independent review entity to get all medical records from us and any Provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

We will determine if your request qualifies for independent review and will refer all eligible requests to the Kentucky Department of Insurance, who will assign an independent review entity. Independent review entities are assigned on a rotating basis so that we do not have the same independent review entity for two consecutive external reviews. We will inform you in writing of the independent review entity that will conduct the review and inform you of your right to submit additional information to the independent review entity within 5 days. If the independent review entity receives the information within 5 days they will include it in their review and forward a copy to us within one day. We will also forward all information required to be considered for an external review to the independent review entity within three business days of assignment.

You will be assessed a filing fee of \$25 to be paid to the independent review entity. This fee may be waived if the independent review entity determines that the fee creates a financial hardship on you. The fee shall be refunded if the independent review entity finds in your favor. If you send in multiple requests for external review within a one-year period, you will not have to pay more than \$75 per year in filing fees. We will pay the rest of the cost of the external review.

The independent review entity will send a written decision to you within 21 days from the date they get of all information required from us. An extension of up to 14 days may be allowed if agreed to by you and us. In no event will the independent review entity take longer than 45 days to complete their review.

You will not be able to get an external review of an Adverse Determination if:

- Your Adverse Determination has previously gone through the external review process and the independent review entity found in our favor; and
- No new relevant clinical information has been sent to us since the independent review entity found in our favor.

If a dispute arises between us and you about the right to an external review, you may file a complaint with the Kentucky Department of Insurance. Within five days of the date they get your complaint, the Department will make a decision. They may direct us to send the dispute to an independent review entity for an external review if they find that the dispute involves denial of coverage based on Medical Necessity or the service being Experimental / Investigational and all other external review requirements have been met.

Expedited External Reviews

External reviews shall be done in an expedited manner by the independent review entity if you are hospitalized, or if, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing your health or, with respect to a pregnant woman, your health or your unborn child's health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Expedited reviews are also available if you are requesting review of a decision that a recommended or requested service is Experimental / Investigational and your Physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

You may pursue an expedited external review while simultaneously pursuing an expedited internal appeal.

The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by you, your authorized representative or a Provider acting on your behalf and with your consent. Requests for expedited external review shall be sent by us to the independent review entity within 24 hours of receipt. We will call the independent review entity to confirm that a specialist is available and that the review has been accepted.

For expedited external review, a decision shall be made by the independent review entity within 24 hours of getting all information required from us. An extension of up to 24 hours may be allowed if agreed to by you and us. We will provide notice to the independent review entity and to you the same day that the Adverse Determination has been assigned to an independent review entity for expedited review. In no event will the independent review entity take longer than 72 hours to complete their review.

The Decision of the Independent Review Entity

The independent review entity shall provide you, your treating Provider, the Kentucky Department of Insurance and us a decision which shall include:

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

Records provided to independent review organizations are handled as confidential records.

The decision of the independent review entity will be binding on us and you except to the extent that there are remedies available under applicable state or federal law.

Who to Contact for Appeals and External Review

The request for an internal appeal or an external review and supporting documentation must be sent to the address or phone number below or to the appeal address or phone number provided on your written notice of an adverse decision:

Position: Appeals Coordinator
Address: **For medical, Prescription Drug or Pharmacy issues:** P.O. Box 105568, Atlanta, GA 30348
For “Vision Services for Members Through Age 20” issues: Blue View Vision, 555 Middle Creek Parkway, Colorado Springs, CO 80921
Phone: 502-261-0294 or 1-888-650-4047
Fax: 1-800-833-6161

The person holding the position named above will process your request.

We encourage you to submit any requests for appeals or external review in writing. The request should describe the problem in detail. Please attach copies of bills, medical records, or other appropriate documents to support your position.

You must file appeals on a timely basis. You are encouraged to file internal appeals within 60 days of the date you get our initial decision, and must file internal appeals within six months of the date you get our

initial decision. If the right to external review exists as described above, you must file the external review request within 4 months of the date you received our final decision on your internal appeal.

Kentucky Health Insurance Advocate

In addition to contacting us, you can also contact the Kentucky Health Insurance Advocate at the Kentucky Department of Insurance for assistance with the appeals and external review processes described above. You can contact the Insurance Advocate by email at DOI.CAPombudsman@ky.gov or you can call 877-587-7222.

Medical Services

We are not liable for Covered Services that you do or do not get from a Provider. You shall have no claim against us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

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

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

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

Dependents

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

- The Subscriber's spouse 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:

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

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

If your Plan is offered through a public exchange operated by the state or federal government as part of the Patient Protection and Accountable Care Act ("Exchange"), all enrollment changes must be made through the Exchange by you or your Group. Each Exchange will have rules on how to do this. For plans offered on the Exchange there are additional opportunities for Special Enrollment. They include:

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

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

Medicaid and Children’s Health Insurance Program Special Enrollment

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

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

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

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they 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.

If additional Premium is required, your newborn’s coverage will only continue past the initial 31 days if you send us the application / change form and pay the additional premium within 31 days of the birth.

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.

We will cover your child under this Plan once we get the application from you, the child's other parent, the Cabinet for Health and Family Services.

After the child is covered, and as long as you are eligible under this Plan, we will continue to cover the child unless we get satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another health plan that provides comparable health coverage.

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. We will return any unearned Premium as required by Kentucky law.

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.

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 Allowable Amount for such services, less any Copayments made or Premium paid for such services.
- 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.

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

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

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

Continuation of Coverage Under 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 |
|--|------------------------------------|
| <p><u>For Subscribers:</u></p> <p>Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</p> | <p>18 months</p> |
| <p><u>For Dependents:</u></p> <p>A Covered Subscriber’s Voluntary or Involuntary</p> | |

| Initial Qualifying Event | Length of Availability of Coverage |
|--|---|
| 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 |
| <u>For Dependent Children:</u> | |
| Loss of Dependent Child Status | 36 months |

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

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code 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.)

Continuation of Coverage Under Kentucky Law

Any Subscriber whose coverage in this Plan ends may continue coverage for themselves and for any Dependents if the Subscriber was covered under this Plan, or a group plan it replaced, for at least 3 months. Coverage will be continued at the Group Premium rate.

The Subscriber will be sent an offer of continued coverage at his or her last known address. To continue coverage, the Subscriber must send in the Premium and written application for coverage no later than:

- 31 days after coverage ends if the Subscriber is given a written notice of the continuation option when their coverage ends; or
- As soon as possible after they have been given written notice of the continuation privilege if the Subscriber did not get notice when their coverage ended; but
- In no event, later than 60 days after the initial 31-day continuation period ends.

Continuation of coverage will end on the earlier of:

- 18 months from the date the Subscriber's coverage would have otherwise ended under the Group Contract because their employment or membership in the Group ended;
- The date through which the Subscriber timely paid the Group Premium rate; or
- The date this coverage ends and is not replaced within 31 days by other coverage.

Continuation of coverage will be available to a surviving spouse and Dependent children if the Subscriber dies or divorces. Continuation of coverage will also be available to any covered Dependent child whose coverage ends because they have reached the age limit under this Plan.

Please note that this continuation of coverage is not available to Members that are covered by, or eligible for, Medicare or other group coverage.

Conversion

Any Member covered under this Plan, or any Group plan it replaced, for at least 3 months may buy a conversion health plan when coverage under this Plan ends. The conversion health plan will have benefits similar this Plan.

We will send the offer of the conversion plan to the Subscriber at their last known address. To buy the coverage, we must get the Premium and written application for the conversion plan no later than:

- 31 days after coverage ends if the Subscriber is given written notice of conversion option when their coverage ends; or
- 60 days after the Subscriber is given written notice of the conversion plan option, if we failed to send the offer when their coverage originally ended.

Please note that conversion coverage is not available to Members eligible for, or covered by, Medicare or another contract providing similar benefits. It also is not available if issuing the conversion contract will make the Member over insured according to our rules.

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.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status).

Coverage continues even if the Plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

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 the Group Contract Ends

If you are Totally Disabled on the date the Group Contract ends and you are not eligible for another health plan, you can continue to get Covered Services for the Total Disability. Benefits will continue until the earliest of the following:

1. Your Total Disability ends;

2. You get coverage for the Total Disability under another group policy;
3. You get the maximum benefits under this Plan; or
4. 12 months have passed since the Group Contract ended.

Benefits will be limited to the condition(s) causing Total Disability. All terms and conditions of this Plan will continue to apply.

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 Kentucky, 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 Kentucky. 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 Health Plans of Kentucky, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Group for any of Anthem's obligations to the Group created under the Contract. This paragraph shall not

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

Entire Contract

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

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

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

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, 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.

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.**

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.

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, will 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, to the fullest extent permitted under applicable law, discretion to determine administration of your benefits. Our determination shall be binding, subject to any rights of complaint and/or appeal provided under the Plan or under applicable law. This may include, without limitation, determinations of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowed Amount. However you may utilize all applicable complaint and/or appeals procedures specified in the Booklet or otherwise required by applicable law. This reservation of discretionary authority shall not be used in such a manner as to deny coverage clearly set forth in the Booklet or to arbitrarily construe or abuse the provision of benefits or rights of appeal under the Plan. This reservation of discretionary authority does not prohibit you from seeking judicial review of our determination after exhausting administrative remedies.

We, or anyone acting on our behalf, will have all the powers necessary or appropriate to enable it to carry out our 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 Booklet. 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 subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary 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 of to us if we have made or makes 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.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this

Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

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 the Group Contract Ends."

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

Covered Transplant Procedure

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

Custodial Care

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

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

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,

- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

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

Deductible

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

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)

Please see the "What's Not Covered" section.

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.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group

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

Group Contract (or Contract)

The Contract between us, Anthem Health Plans of Kentucky, Inc., 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.

In-Network Transplant Provider

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

Inpatient

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

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)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury that is determined by us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member’s condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member’s illness, injury or disease, the service is not more costly than an alternative service or sequence of services that is medically appropriate;
- Not Experimental / Investigational;
- Not primarily for the convenience of the Member, the Member’s family or the Provider.
- Not otherwise subject to an Exclusion under this Plan.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

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-Network Transplant Provider

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

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 consists 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.

Recovery

Please see the “Subrogation and Reimbursement” 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.

Total Disability (or Totally Disabled)

A condition where you are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. We may require your Physician to send us proof of your condition.

Transplant Benefit Period

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

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.